Title:

"I found myself having slept with him": Vulnerability to HIV and the first sexual encounter as described by six young Basotho women.

By

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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ABSTRACT

This study is a qualitative exploration of the first sexual experiences of six young Basotho women between the ages of 16 and 24 and how these experiences leave them vulnerable to HIV/AIDS. The six young women were interviewed using a semi-structured interview schedule focusing on first sexual experiences and knowledge of HIV/AIDS. The interviews were recorded, transcribed and translated from Sesotho into English. Transcripts were analysed using thematic analysis. The themes which emerged were elucidated by linking the findings to the current literature on the vulnerability of young women to HIV/AIDS infection in sub-Saharan Africa. The dominant themes which emerged were: young women are engaging in sexual activity in early adolescence when issues of identity are still being negotiated, they have had little if any opportunity to discuss sex, love and intimacy and to develop their own thoughts about these issues, almost no guidance is offered by parents, teachers or other adults in these matters, peers and siblings are the main source of information and influenced these young women's attitudes towards sex, there was a high level of pressure and coercion by the young women's partners to have sex, there was a disturbing lack of knowledge of reproductive health and misconceptions about the prevention and spread of sexually transmitted infections and HIV/AIDS. The study concludes with a consideration of the limitations of this research and recommendations are made for the development of intervention strategies.

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CHAPTER ONE

1. BACKGROUND TO THE STUDY

1.1 Lesotho and Poverty

Lesotho is situated in Southern Africa. It is completely surrounded by South Africa. The nation was formed by King Moshoeshoe the First (1786-1870) who had welcomed different ethnic groups in Southern Africa seeking protection from, among other things, the wars in the region at that time (Letuka, Matashane and Morolong 1997). As a result of the wars waged against nation by the Afrikaner settlers, Lesotho lost land to what is today South Africa's Free State Province. The nation then became a British protectorate and as result managed to retain what is now present day Lesotho (Letuka et al. 1997)

The 30 000 sq km of land that is Lesotho is mostly mountainous terrain, and less than 10% is arable land (Letuka et al. 1997). Lesotho is divided into 10 districts and the capital city is Maseru. Lesotho has a population of 2 200 000 (Lesotho Bureau of Statistics, 2003). According to the United Nations Children Fund (UNICEF), (2003) 80% of the country's population depends on agricultural production for their livelihood and there has been a gradual decline in agricultural production. The majority of the population survives through subsistence farming and the country has depended on the wages of migrant labourers as a key source of income for many decades (Letuka et al.). According to Francis (2000) the Southern African region has relied a great deal on migrant labour and South Africa's mines have played an important role in employing a large majority of males from Lesotho over the years. However, the retrenchments in the mining industry in South Africa have affected a substantial number of Basotho (Basotho describes a collective noun for people living in Lesotho) men. Francis (2000) highlights that there has also been a growing tendency for the South African Chamber of mines to retrench their foreign labourers and recruit within their own borders.

According to UNICEF Lesotho is one of the poorest countries in the world, it is ranked at 120 on the United Nations Development Index out of the 162 countries listed. It is estimated that 58 % of the country's population is living below the poverty line. Nearly, half a million people are facing a humanitarian crisis of famine (UNICEF, 2003). According to the Lesotho Bureau of Statistics (2003) there is an unemployment rate of 31.4 % in the country.

1.2 Lesotho and HIV/AIDS

According to UNICEF (2003) the National prevalence rate for HIV/AIDS in Lesotho is 31%, whilst for the capital city Maseru the prevalence rate is estimated to be 40% of the population. According to the United Nations Population Fund Special Focus: "Making 1 Billion Count" program half of all new HIV infections are in young people between the ages of 15 to 24 (United Nations Population Fund-UNFPA, 2003). Some of the factors which are believed to be contributing to the high rate of HIV infections in the country are poverty, rural-urban migration, school drop-out rates and an increasing number of young girls engaging in sex work.

Initiatives in the country have targeted adolescent health needs for those in and out of school. The Ministry of Health and Social Welfare has within it the National Adolescent Health Promotion and Development Programme (NAHPDP) which collaborates with non-governmental organizations (Adolescent Health Newsletter, 1999). Following a needs assessment study commissioned by the department of Health and Social Welfare, in response to the growing needs of adolescents in the country, three service centers were established (Motlomelo and Sebatane, 1999). These centers work largely with adolescents, most of whom are pregnant, and they provide services such as pre-natal care, counseling, life skills and psycho-education on reproductive health. All interviewees in this study were located in the Maseru district, four at the local service center and two from a surrounding village.

1.3 The Rationale for the study: Shifts in research into the spread of HIV/AIDS

According to Eaton et al. (2002) there has been a vast amount of research done in the field of HIV/AIDS in the hope of understanding its rapid spread. Sub-Saharan Africa has been shown to be the region hit the hardest by the HIV/AIDS pandemic (Eaton et al.; Gilbert and Walker, 2002; Jackson, 2002).

This rapid spread of the pandemic in sub-Saharan Africa has been acknowledged for more than a decade now. In the early 1990s, sub-Saharan Africa was identified as the region most widely affected by this seemingly relentless pandemic (Farmer, 1996; Mwale and Burnard, 1992). Some literature was predicting increasing rates of infection, estimating that the number of those infected would be in the 30 million range by the year 2000 (Mwale and Burnard, 1992).

In spite this knowledge and predictions made, the infection rates have continued to grow unimpeded. One of the possible factors that may have played a role in the poor understanding of what has been driving the HIV/AIDS pandemic is that early research on the HIV/AIDS pandemic failed to consider the role that social and structural factors play in the spread of HIV/AIDS (Eaton et al. 2002). In looking at the epidemiology of HIV/AIDS, research has often emphasized individual agency as the main explanation for its spread (Farmer, 1996; Giffin and Lowndes, 1999 and Eaton et al.).

Griffin and Lowndes (1998) note that the vast majority of research on sexually transmitted diseases concentrates mainly on investigating high risk behaviours and issues around individual behaviour. A study by Eaton et al. (2002) highlights that the "social cognitive theories", which primarily address personal and interpersonal processes within the individual, have been used to explain sexual behaviour. The study's critique of these theories is that they neglect other social influences such as culture and poverty. Furthermore Farmer (1996) notes that such neglect has meant that terms such as racism, poverty and gender inequality were initially not considered as part of the discourse which developed to explain the spread of HIV/AIDS. Similarly, Venier, Ross and Akande (1998)

also note that most studies in sub-Saharan Africa have previously focused on false beliefs about AIDS, sexual practices and or knowledge of AIDS as a way of understanding the spread of HIV/AIDS.

Wood, Maforah and Jewkes (1998); Eaton et al. (2002) and Kesby, Fenton, Boyle and Power (2003) note however that there has been a shift in emphasis in recent studies especially in underdeveloped regions. Eaton et al. have noted studies that highlighted factors influencing adolescent high risk behaviour; including poverty and cultural norms. Amongst other things poverty contributes to a lack of education and adequate reproductive knowledge. Cultural norms may impact on the level of submissiveness and coercion in sexual relations for youth (Eaton, et al. 2002; Baylies, 2000). In addition, intense taboos around discussing sexuality, highlight the problems of poor communication between generations (Bujra, 2000; Ngom, Magadi and Owuor, 2003).

MacPhail and Campbell (1999) propose that a problem that is adding to the slow progress of HIV prevention evidenced in developing countries is the dominance of the biomedical approach. Interventions based on biomedical approaches tend to lack participatory methods which involve collaboration with the community. Furthermore, on evaluating existing programs, methods of evaluation rely too heavily on quantitative methodologies which although useful do not provide a complete picture of why projects are working or failing. The authors maintain that "a great deal more qualitative research remains to be done in the interests of developing quantifiable indicators of intervention success" (MacPhail and Campbell, 1999: 160).

Zeleza (2002) introduces an additional perspective on the relative ineffective impact of research in Africa by observing that social science research in Africa is largely controlled by governments, donor agencies and civil society. This has had implications for what is studied and the methodologies employed by such studies. Furthermore, the relevancy and thoroughness of social science research studies in the African context has been less than optimal (Zeleza, 2002). Prevention programs are often informed by Western context oriented research. Research that is particular to a specific region in sub-Saharan Africa is

thus limited. When localized research studies have been undertaken, they have been found to be useful, particularly when the findings are integrated into developing prevention programs specific to those localized research sites (Wood et al. 1998; Suleman, 1999). Furthermore Motlomelo and Sebatane (1999) point to the lack of research into what, if anything, has replaced traditional social structures that are used to educate young people about adulthood. They also assert that existing violence amongst young people in Lesotho has received little attention and there is little knowledge about its impact in the spread of HIV/AIDS. Adolescent health has been largely ignored in Lesotho for many decades and only in recent years has it been addressed. There is also a lack of research in the understanding of adolescent issues from the adolescent's perspective. This study hopes to open up an area of research that tries to understand young women's experiences of their own sexuality in Lesotho.

1.4 The Aims of this study

In this study I hoped to broaden our understanding of why young Basotho women are vulnerable to HIV infection. In order to do this a consideration of the macro factors that have been identified in current literature as contributing to the unimpeded escalation of the HIV/AIDS pandemic in sub-Saharan Africa, in particular in Lesotho, is needed. This understanding of macro influences must be counterbalanced by an understanding of the micro factors influencing the spread of HIV in young Basotho women. By exploring the first sexual experiences of six young Basotho females I aimed to:

- Gain some understanding of what their reasons were for engaging in sex
- Explore who or what influenced their knowledge and attitudes around sex
- Ascertain the age of first sexual encounter
- Gain an understanding of how they experienced their first sexual encounter
- Gain some idea of their knowledge of reproductive health
- Explore experiences of violence and coercion in their sexual experiences

1.5 Conclusion

There has been a concerted effort in many countries, through government ministries and non-governmental organizations, to educate and inform populations about HIV/AIDS in an effort to prevent the spread of HIV/AIDS. Preventative measures have largely been informed by the biomedical understanding of the spread of the pandemic (Giffin and Lowndes, 1999). For a long period in Southern Africa the knowledge-attitude-belief-practice (KABP) paradigm was dominant in influencing prevention approaches although a visible shift from this paradigm has been noted in recent research (Wood and Foster, 1995).

Prevention efforts in Southern Africa have had limited impact as evidenced by the continuing escalation of the HIV/AIDS pandemic in sub-Saharan Africa. Young African women are particularly vulnerable and have been the most affected by HIV/AIDS (Baylies, 2000); they have higher rates of infection and have the lowest rates of survival (Gilbert and Walker, 2002). It is clear that there is a gap between understanding what is driving the HIV/AIDS pandemic and the prevention programmes instituted by the various stakeholders in the field. This study aims to in some way lessen that gap, by seeking to understand young women's perspectives, experiences and understanding of early sexual relations.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 Introduction

This chapter gives an overview of the key focus areas in the current literature which are believed to be influencing the continuing spread of HIV/AIDS in sub-Saharan Africa. The chapter does not deal with the physiological and medical factors that impact on HIV/AIDS transmission but acknowledges their importance. The main thrust of this chapter is a review of the literature that specifically looks at the various ways that the HIV/AIDS pandemic highlights the vulnerability of young women in many societies, but particularly in sub-Saharan Africa.

Firstly the developmental stage of adolescence will be considered, with particular focus on the issue of identity and sex and sexuality in this phase of development. This will be followed by a consideration of adolescent identity and sexuality in the Western context and then in sub-Saharan Africa. Thereafter the link between poverty, sex and the spread of HIV/AIDS will be considered, particularly with regards to poor women in sub-Saharan Africa.

The impact of unequal power relations on the spread of HIV/AIDS amongst women is then considered, with particular focus on patriarchy in African societies. This is followed by a discussion of sex and gender-based violence as it relates to the continuing spread of HIV/AIDS amongst women in sub-Saharan Africa. Finally consideration is given to HIV/AIDS prevention programmes, highlighting some of their limitations linked to their failure to consider key issues such as adolescence, gender relations and poverty in an African context.

2.2 Adolescence

It is largely agreed that adolescence is a transitional stage between childhood and adulthood. It is noted by Graber, Brooks-Gunn and Galen (1998) that adolescents experience their status as ambiguous because they are not completely accepted as adults and yet they are much more competent and independent than children. Erikson (1959, 1968) cited in Moore (1999) has made substantial theoretical contributions to our understanding of adolescent development. According to Moore (1999), Erikson saw the main tasks of adolescence as being the establishment of identity and linked this to coping with sexuality. The formation of identity was crucial in Erikson's view. He expressed it thus, "For, indeed, in the social jungle of human existence there is no feeling of being alive without a sense of identity" (1968: 130). In addition dealing with sexuality is viewed as an important part of identity formation for young people in this developmental stage. It is also proposed that falling in love for adolescents is not just about sexual feelings, it "is an attempt to arrive at a definition of one's identity by projecting one's diffused self image on another and by seeing it thus reflected and gradually clarified" (Erikson, 1968: 132).

Graber et al. (1998) note that adolescence has various transitions that are largely marked by physical, cognitive and social developments. Adolescents experience various physiological changes during puberty and coming to terms with bodily changes as well as managing sexual feelings is part of the task adolescents are faced with. They also have to develop beliefs and values around sexuality. Hook (2002) has also highlighted how important peers are in the adolescent's life. Peers help the adolescent establish a 'firm identity'. Often through identifying with each other they share going through the awkwardness of this stage together (Hook, 2002).

Adolescents are required to incorporate as part of their developing identities the social norms of gendered sex roles particular to their context (Moore, 1999). Thomson and Holland (1998) go so far as to conclude that it is the very process by which young people learn about sex that leads them to taking up gendered roles.

Graber et al. (1998) highlight that the cognitive skills of adolescents also increase as they enter into culturally defined transitional events such as moving from middle school to high school. The increase of cognitive skills, including social cognitive skills during adolescence has been highlighted by various researchers (Winn, Roker and Coleman, 1998). In addition, sexual exploration occurs during the adolescent years and the negotiation of autonomy and intimacy often takes place within sexual situations. Developing the skills to control the consequences of sexual behaviour is part of such negotiations.

The culturally defined transitions referred to in the previous paragraph are shaped by historical, cultural and economic contexts as well as the social context of the individual (Graber et al. 1998; Hook, 2002). In light of this, the writer deems it important to consider the development of adolescent sexuality in the West in order to contrast and compare it with adolescence in sub-Saharan Africa.

2.2.1 History of adolescence and sexuality in the West

Graber et al. (1998) note that in America up until the 1960s, societal norms about sex were such that sexual intercourse was seen as only appropriate in marriage and was thus not seen as separate from reaching adulthood and taking on an adult role. Historical changes in the 1960s resulted in greater acceptance of premarital sex for adults. One of the consequences of those changes was that the age of first sexual intercourse began to decrease (Graber et al. 1998; Winn et al. 1998).

Furthermore, in most Western societies, marriage is no longer a key marker for the transition to adulthood. This has been attributed, at least in part, to the advances made in birth control methods and the increased societal acceptance of premarital sexual intercourse, especially for adults. Permissive sexual norms have generally become acceptable and with that the number of teenagers having sex has increased (Graber et al.

1998; Moore and Rosenthal, 1998; Winn et al. 1998). Moore (1999) also suggests this apparent permissive attitude towards sexuality in Western societies seems to have been greatly driven by the media. Thus sexuality and sexual behaviour accepted in adults has also become part of adolescent behaviour (Graber et al.).

However, it is also noted by Graber et al. (1998) that whilst sexual activity has become normative in adolescence it is not accepted as such by older authority figures. Parents and organized religion may hold conservative views where adolescent sexuality is concerned. This is in stark contrast to the messages given by the media encouraging and glamorizing permissive attitudes towards sexuality. This leaves adolescents confused and conflicted about their expectations, the expectations of others and their sexual choices (Moore, 1999). The disparities between what different groups consider to be acceptable sexual activity for adolescents has also led to intense disagreement over strategies for combating teen pregnancy and threats to health, most starkly highlighted in the debate between promoting abstinence versus distributing condoms for the prevention of the spread of HIV/AIDS (Graber et al.).

2.2.2 The paradox of adolescence and sexuality

Graber et al. (1998) citing Zabin and Hayward (1993) note that sex in early adolescence has unhealthy consequences for various reasons. The younger the age of first intercourse, the longer the exposure to risks associated with intercourse such as diseases or early pregnancy. Younger adolescents may be less responsive to intervention targeting sexual risks because they are unlikely to have developed advanced cognitive and social skills as they are often in the process of developing decision making skills and an understanding of behavioural choices (Graber et al.) The decrease in the age of first sexual encounter has put adolescents in a precarious situation where the adolescent must recognize situations in which sexual behaviour is more difficult to control, where the individual may be coerced or pressured into having sex and when s/he may seek intimacy but get sex instead (Graber et al.).

Moore (1999) highlights that adolescents are often exposed to mixed messages, messages which continue to leave them without a clear direction about their actions. Gender socialization and sexual stereotyping suggests that it is much more difficult for boys to control their sexual drive and by implication therefore it is girls who are seen to be responsible for controlling sexual situations by refusing to have sex. At the same time Wood (2001) notes that girls and women are socialized to be accommodating and to try and please men. Men are encouraged to be dominating and to treat women as weak. Young girls are brought up to view sex as part of affection, intimacy and love whereas young men are likely to be socialized into viewing and experiencing sex as a physiological release and conquest, placing young people, both boys and girls in a vulnerable position to being hurt and disappointed (Moore, 1999). Little wonder then that young people are confused about what is expected of them. Perhaps even more so for young women; Jackson (2001) found that young women have a tendency to seek affirmation from relationships with boyfriends when they are having problems either at home or with friends and so on. This becomes the solution for their problems and this leaves them vulnerable to experiencing violence and coercion in the relationship.

In the West, such mixed messages do have consequences, nevertheless there are protective factors for adolescents which allow the majority of youth to develop sexually without the consequences of early pregnancy and sexually transmitted diseases such as HIV/AIDS. These factors include better access to resources such as human capital (such as education and information), cultural capital and social capital. Minority groups in the Western context do not, however, enjoy such protection.

2.2.3 Adolescence, sexuality and the African context

The context of adolescence in sub-Saharan Africa, particularly Southern Africa, is different to that of adolescence in more developed societies. There had been a lack of research in the area of adolescent development in this context until HIV/AIDS began to spread. Subsequent research is relevant because of the links made between adolescence

and the spread of HIV/AIDS in sub-Sahara Africa. Eaton et al. (2002) mention environmental factors which are influenced by structural factors such as poverty and culture, and these play a significant role in limiting young South Africans in making full use of preventative measures or having alternatives available to them. These factors are commonly experienced by the majority of young people in sub-Sahara Africa, particularly Southern African. Thus MacPhail and Campbell's (2001: 1614) reference to Holland et al.'s, (1990) definition of sexuality is pertinent:

> By sexuality we mean not only sexual practices, but also what people know and believe about sex, particularly what they think is natural, proper and desirable. Sexuality also includes people's sexual identities in all their cultural and historical variety. This assumes that while sexuality cannot be divorced from the body, it is also socially constructed.

Development issues that youth in the West struggle with are similar to those that youth in sub-Sahara Africa grapple with, however youth in sub-Saharan Africa have to deal with social factors such as endemic poverty, gender oppression and rigid cultural norms. More than any other disease, HIV/AIDS has demonstrated that there is a link between the social and the private spheres of human interaction and that sex even as a private act is greatly influenced by social factors (Baylies, 2000).

2.2.4 African youth and age of the first sexual encounter

It has been largely acknowledged that sub-Sahara African youth make up one of the most vulnerable groups in terms of being at risk to HIV infection (Eaton et al. 2002). One of the problems identified in sub-Saharan African youth is that a large majority of them have sex early in life. In Lesotho for example, in some areas, the Joint United Nations Programme on HIV/AIDS-UNAIDS (2002) estimates the age of first sexual encounter among Basotho girls to be 14 and even younger for boys. An earlier study in 1992 had put the age of first sex at 16. Eaton et al. (2002) and Harrison, Xaba, Kunene and Ntuli

(2001) show that in South Africa, by age 16, at least 50% of young people are sexually active. Ngom et al. (2003) highlight that in Kenya the age of first sex is estimated to be16 years of age.

In comparison, studies in the United Kingdom according to Moore and Rosenthal (1998) estimated age of first sex around 16 and 17 years. Similarly in Australia, estimates were around age 17. In the United States, a great majority of adolescents had been sexually active by age 19 (Moore and Rosenthal, 1998). Moore, Rosenthal and Mitchell (1996) note, however, that it is misleading to imply an average age of initiating sex as there are differences between groups, sub-groups and countries. Moore and Rosenthal (1998) note that studies have shown that there are social differences in terms of ethnic, race and religious groupings. In Southern Africa, peers played a key role in pressurizing younger inexperienced girls to become sexually active, by ostracizing them for their inexperience and denying them knowledge about sex and intimacy (Wood, Maforah and Jewkes, 1996). Harrison et al. (2001) also argue that, with regard to African youth, it may only be a small proportion of young girls who engage in early sexual initiation and argue that more research ought to be done to assess who is at higher risk. Such research would also enhance our understanding of what factors are at play in different groups which encourage or discourage sex at a young age.

2.2.5 High risk sexual behaviour

Eaton et al. (2002) describe high risk behaviour in three ways; i. the mere fact of being sexually active, ii. having many partners at a time and iii. practicing unprotected sex. Ngom et al. (2003) highlight that youth in Kenya engage in high risk behaviour sexually, the majority of them do not perceive themselves to be at risk for HIV infection and rarely practice safe sex. According to Eaton et al. (2002) there is high risk sexual behaviour among youth in South Africa as is also noted by Wood et al. (1998).

Youth generally evidence a reluctance in using condoms consistently even in Western societies, this is attributed to factors such as low self-esteem. Youth who had low self

esteem were unlikely to feel they had a right to protection or felt unable to insist that their partners use condoms. In addition young people were likely to use condoms when the relationship was still new, once the couple became steady, the contraceptive pill becomes a preferred method (Gerhardt, Kuyper and Gruensven, 2003). Thomson and Holland (1998) and Wood and Foster (1995) also highlight that socialization into stereotypical feminine and masculine roles and attitudes may contribute to inadequate safe sex practices. Deeply held beliefs around condoms and sex impact on the negotiation of condom usage. Young people have, for example, been shown to view AIDS as something that is external and thus see condoms as only necessary to use with prostitutes or someone perceived to be 'loose' sexually (Wood and Foster, 1995, MacPhail and Campbell, 2001).

Youth in sub-Saharan Africa, especially Southern Africa, face additional problems of violence and coercion in relationships. Wood et al. (1998) and Shefer, Strebel and Foster (2000) have highlighted the prevalence of coercion and violence in sexual behaviour amongst Southern African youth. Baylies (2000), Harrison et al. (2001) and Jackson (2002), also highlight that transactional sex is often an issue for African youth. In the words of Baylies (2000:7) "indeed sex has been referred to as the currency by which women and girls are frequently expected to pay for life's opportunities, from a passing grade in school to a trading license or permission to cross a border". The implications for the spread of HIV/AIDS in such situations are obvious.

2.2.6 Intergenerational communication

Bujra (2000) highlights the difficulties that parents of youth in sub-Saharan Africa usually have in discussing topics related to sex, intimacy and sexuality with their children and especially adolescents. Such topics are seen as taboo and when young people bring them up they are reprimanded for being disrespectful. Mturi and Hennink(2002) have also observed this difficulty in Lesotho; parents do not discuss issues relating to sex with their children. Parents appeared to find talking to their children and adolescents very

difficult to do because it evoked feelings of shame and embarrassment. Most parents felt that teachers should be the ones to talk their children (Mturi and Hennink, 2002). Motlomelo and Sebatane (1999) have also noted a lack of communication between parents, teachers and adolescents around sex. They have noted that adolescents in previous generations used to have available to them some form of preparation into adulthood from initiation ceremonies and adults playing particular roles as leaders in the community but young people today lack this preparation.

Parental supervision and involvement and family support plays a major role in improving social circumstances in later life for youth with poor socioeconomic backgrounds (Ensminger and Juon, 1998). Youth who delay becoming sexually active often have social support that rewards this decision; parents and religious groups endorse such choices. Adolescents can shape their environment by seeking contact with supportive peers or those who with similar values, this way they determine the extent to which they feel pressure to adhere to social norms and having sex (Ensminger and Juon, 1998). Jackson (2000); Murray (1981); and Lurie (1999) have commented on the dependency of Southern Africa on migrant labour, the impact of migration and how this has contributed to the disintegration of the family and tension within families. This has also meant the absence of fathers and father figures in communities. Kimani (1981) proposes that rural urban migrancy amongst youth in Lesotho has had a negative influence in terms of their kinship relationships. This loss of connection with kin folk leaves young people vulnerable to many outside influences and contributes to their engaging in high risk behaviour, including high risk sexual behaviour (Kimane, 1981). Given Ensminger and Juon's (1998) findings, the above factors are likely to have a profoundly negative impact on high risk sexual activity amongst youth in Southern Africa.

2.2.7 Perception of HIV/AIDS risk

According to MacPhail and Campbell (2001), Eaton et al. (2002) and Wood and Foster (1995) the majority of South African youth do not perceive themselves at risk for HIV infection. They also tend to deny the presence of AIDS in their communities. In their

research MacPhail and Campbell (2001) found that young people tend to perceive themselves as unlikely to be at risk for HIV infection. Young males in particular tended to deny the risk more than females. Research also seems to suggest that condom usage is associated with 'prostitutes' (sex workers), or 'unclean' people with STDs, thus the HIV threat is externalized onto others (Macphail and Campbell, 2001; Wood and Foster, 1995).

2.2.8 Lack of knowledge and limited opportunities to acquire knowledge

Eaton et al. (2002) noted from research done by Blecher et al. (1995), Elkonin (1993) and Harvey (1997) that there are serious gaps in knowledge youth have about how HIV is transmitted and prevented. In addition Baylies (2000) suggests that African women's vulnerability is exacerbated by the fact that African women have limited access to education and low levels of literacy and this limits their access to information on reproductive health. These limitations are critical because, as emphasized by Winn et al. (1998), adequate knowledge about sexual and reproductive health is essential in informing young people's ability to make informed decisions regarding sexual behaviour.

Furthermore, condoms are not easily accessible to youth for various reasons; clinic staff are reported to have condemnatory attitudes towards youth attempting to acquire condoms, poorer areas may not have condoms to distribute, there is a general lack of health care staff with the right skills to deal with the specific nature of adolescent needs particularly for those in rural and peri-urban areas and there is also limited access to the media for information (Eaton et al. 2002).

2.2.9 Summary

The period of adolescence is characterized by many theorists as a developmental phase within which the issue of identity is central. Establishing an identity as a young adult is intertwined with physiological changes which foreground sex and sexuality as a key component of identity. Thus the dilemmas faced by the adolescent places him/her in a

particularly vulnerable position in relation to sexuality, sexual activity and thus HIV/AIDS. In addition there are obvious discrepancies between what is expected of the adolescent from parents, organized religion and the messages communicated through the media about adolescent sexuality, which is likely to leave young people confused (Moore, 1999). These factors are likely to intersect in different ways in various contexts. In African societies, young people, particularly girls and women have been found to be vulnerable to HIV infection, not only because of their physiological vulnerabilities, but also because of their psychosocial and cultural contexts (Baylies, 2000).

2.3 Poverty, HIV/AIDS and women

Gilbert and Walker (2002) highlight that the concept of vulnerability has been used a great deal in HIV/AIDS literature and they attempt to validate its use by expanding on it. According to Oppong (1998) cited in Kalipeni (2000) all people have a biological propensity to be infected by various diseases however some individuals and groups become more vulnerable to infection because of particular social and economic factors (both cited in Gilbert and Walker, 2002). Gilbert and Walker (2002) emphasize a broad spectrum of factors, both at a macro and micro level which make people vulnerable to infection or disease. They note that poverty and discrimination on the basis of both race and gender are some of the social factors that have put African women in South Africa in a vulnerable position.

The rate of HIV/AIDS infection and the disproportionate number of AIDS related deaths which occur in poorer contexts has been increasingly linked to poverty (Farmer, 1996). In addition inequalities in health have been well documented for a very long time, and impact greatly on the spread of HIV/AIDS in marginalized, disempowered groups (Gilbert and Walker, 2002).

2.3.1 Women and poverty in the world

In many countries, developed and underdeveloped, poverty is visited upon certain groupings of people, in developed countries it is largely minority groups and women. In the US for example, African Americans and other minorities bear the brunt of a low socio-economic status. Women, in these communities often experience what Farmer (1996) calls "structural violence". If they are not denied basic rights, such as shelter, food, and education and so on, the conditions within which they live make it impossible to pursue these rights freely. They often do not enjoy the advantages of social and scientific advances, which could improve or save their lives. African American women make up the population most affected by HIV/AIDS in the U.S. (Farmer, 1996). Ciambrone (2003) highlights that women as sub group make up the fastest growing population of people with HIV in the US. She adds that these women also likely to be victims of violence and/ or lack of financial support.

It has been noted that there is a link between one's economic position and one's vulnerability to HIV/AIDS infection. Women across the globe who are at risk for HIV infection have been rendered vulnerable through social conditions such as poverty (Farmer, 1996; Gilbert and Walker, 2002; Eaton et al. 2002). According to Farmer (1996), the majority of poor women around the world feel forced or obliged to continue with relationships which may put them at risk for HIV infection in return for some financial gain. In Haiti, young women who had moved to cities in search of a better life away from their poverty stricken homes admitted freely that they had sexual encounters for financial reasons (Farmer, 1996).

2.3.2 Women and poverty in sub-Sahara Africa

Sub-Saharan Africa, particularly Southern Africa has the highest rates of HIV/AIDS infections in the world, and it is also the poorest region in the world (Gilbert and Walker, 2002; Eaton et al. 2002; Jackson 2002 and Francis 2000). Sub-Saharan Africa is also developing at a much lower rate than other developing countries. According to Francis

(2000) in most sub-Saharan African countries, the majority of people live on less than 1US$ per day, have poor access to clean water and a significant percentage of children under the age of 5 experience malnutrition. Currently Southern Africa is in the midst of a humanitarian crisis, with 14 million people at the risk of starvation (UNICEF, 2003).

Baylies (2000) asserts that the high rate of HIV/AIDS infection in sub-Saharan Africa is by and large the result of extreme poverty and its concomitants: poor nutrition, lack of access to medical care, and the burden of national debt and its impact on provision of services. In this context it is women, especially young women, who are experiencing high rates of HIV infection and AIDS related deaths in sub-Sahara Africa (Baylies, 2000). Baylies (2000) uses the UNDP (1995) gender related index to show that in Africa men enjoy better lives than women. They enjoy more and better employment, have better access to financial resources, are better nourished and participate freely in the public and political sphere. For example, in South Africa, 53 % of those living in rural areas are women and they are also the poorest population, female headed households are likely to be poorer than those headed by males (Gilbert and Walker, 2002).

According to Francis (2000), most of these rural households do not grow enough food to live on. Francis (2000) nevertheless notes that each region has its own history of impoverishment which is often linked to previous colonial systems. In Lesotho, two thirds of the population lives in rural areas, and this population is largely made up of women because of the huge dependency in the country on migrant labour as a source of income. A large proportion of the unemployed in Lesotho are women (Letuka et al. 1997.) As with many developing countries in Africa, Lesotho is a country profoundly affected by the International Monetary Fund (IMF) and World Bank's Enhanced Structural Adjustment Programme (ESAP). In an attempt to service the national debt there have been reductions in subsidies for health, education, social services and other areas of the public sector. The impact of these cuts in service provision is most powerfully evidenced in rural areas (Letuka et al.).

According to Eaton et al. (2002) poverty as a structural factor also has a significant impact on personal beliefs. This was illustrated in the study done by Whitefield (1999) cited in Eaton et al. (2002). The study compared the personal beliefs relating to sexism, of adolescent girls from disadvantaged backgrounds to adolescent girls from advantaged backgrounds. It became clear that girls from higher socio-economic backgrounds rejected sexist ideas, whereas girls from the lower socio-economic backgrounds supported them. It may be that poor women are also more influenced by a patriarchal culture than their well-to-do counterparts. Letuka et al. (1998) note that many researchers have found that women in rural settings seem to value their kin relations more than their non-blood relationships and there seems to be a strong collective conscience that regulates women's thinking in these settings. This may to some extent explain Whitefield's (1999) findings.

2.3.3 On Health and social inequalities

According to Gilbert and Walker (2002) the link between health and social inequalities is well established and has been widely researched. They point out that previous literature has successfully demonstrated the impact of socioeconomic inequalities on health. Nonetheless these inequalities persist. Gilbert and Walker (2002) propose that social class, gender, race and geographic location are some of the social dimensions which continue to be associated with availability of access to health care. They note that each year about 17 million people in developing countries die from curable diseases that affect largely the poorest in the population (EU Development, 2000 cited in Gilbert and Walker, 2002).

Whilst the link between poverty and health is clear, the situation is further complicated by factors such as culture and political structures. Gilbert and Walker (2002) note that the link between poverty and health has mostly been explored through and demonstrated by using the Human Development Index which combines real Gross Domestic Product (GDP), life expectancy and education. The lower the GDP, the lower the life expectancy in that country. By drawing attention to the example of Sri Lanka, Gilbert and Walker (2002) emphasize that social factors, such as culture, influence life expectancy in a country. Thus, although there is a low income level in Sri Lanka, social factors such as

dedication to education, an adherence to principles of egalitarianism and a substantial degree of female autonomy have had a positive impact on the health of the population in general.

2.3.4 Poverty and basic education

Zeleza (2002) observes that Africa is the least educated continent in the world. While developed countries boast 60% of the population receiving higher education, only 3.6% of Africa's population has received higher education. In many African countries women receive the least education. Gilbert and Walker (2002) point out that more girls than boys are likely to be withdrawn from school because of the family's financial needs, which increases their illiteracy, which in turn restricts their access to information and health care as well as education in general.

According to Letuka et al. (1997) in Lesotho girls make up over 50 % of the children enrolled in school and are better educated than their contemporaries in other Southern African countries. Apart from both sexes being affected by lack of school fees, books and so on, boys tend to drop out because of the attraction of working in the mines. Girls drop out of school, later than boys, and they drop out because their families require them to take on domestic work. Young girls also drop out of school because of falling pregnant or getting married (Letuka et al.). Although numerically, women are better educated in Lesotho, Letuka et al. assert that this advantage does not enhance their economic power. They only make up 36 % of the employed population in the formal sector. They also hold the lowest paying grades in the civil service which is a large employer in the country (Letuka et al.).

Poverty has led to a humanitarian crisis in Southern Africa leaving many at the risk of starvation. Women generally bear the brunt of the effects of poverty because of their isolation economically and the discrimination they face because they are women. Engaging in sexual activity for financial reasons or dependence has been highlighted as a crucial issue that puts many women in sub-Saharan Africa in a vulnerable position to

HIV infection (Baylies, 2000; Karim and Frohlich, 2000). As a result of such factors, women are more vulnerable to HIV/AIDS infection and die from AIDS related illnesses at higher rate than men.

2.4 Gender and Power Relations

Francis (2000) highlights the complexity of gender relations, which occur at number of levels such as the material, social, ideological and moral levels of interaction. However caution should be exercised when generalizing about gender relations, since they differ between individual households within the same village and between neighbourhoods and larger towns (Francis, 2000). Nevertheless, a country's law and policies, level of education, and culture often overlap on many levels and may all contribute to placing women in a subordinate position (Baylies, 2000). The very nature of gender relations places women in a submissive position in many cultural contexts, particularly in relation to making decisions around sex and exposure to HIV infection (Baylies, 2000).

Gender relations often affect how men and women behave sexually and the unequal power relations that are intrinsic to gender relations define male and female roles, and their positions in relation to each other (Baylies, 2000). Baylies (2000) notes that in the context of HIV/AIDS, gender relations often inhibit or limit women's ability to protect themselves and their families.

2.4.1 Gender and patriarchy in African societies

An undeniable factor that continues to contribute to certain populations being affected severely by HIV/AIDS is the oppression of women because of cultural values and norms. Patriarchy in a number of African societies, particularly in Lesotho, where it is deeply embedded within the culture, plays a critical role in the oppression of women (Letuka et al. 1997). It has not only been perpetuated through cultural beliefs and practices but also through laws and policies practiced by most African countries with regard to the position

of women in these societies (Baylies, 2000). This oppression will be considered in light of how it continues to contribute to the unimpeded spread of HIV.

According to Airhihenbuwa (1995) cited in Eaton et al. (2002), traditional African cultures are commonly oppressive toward women. Certainly, not all African males use violence or are coercive within relationships, however because of the power automatically entrusted in men in patriarchal societies, men are often the decision makers with regard to when and how sex will occur. There are certain traditional beliefs around male sexuality which may contribute to the sexual subordination of women. These include the belief that, men's sexual desires are biological needs which are uncontrollable and that men need numerous partners to adequately fulfill expectations of their masculine identities (MacPhail and Campbell, 2001 and Foreman, 1999).

Eaton et al. (2002) highlight coercive, male dominated relationships in Southern Africa. Research conducted by Wood et al. (1996) and Wood et al. (1998) illustrates that a lot of young women are physically forced or bullied into having sex. Also young men often believe that they have a right to force a girlfriend into sex by using physical force or verbal threats and intimidation (Eaton et al. 2002). It is clear that issues such as condom use and the negotiation to have sex or not to have sex on the part of women in such situations is difficult if not impossible.

2.4.2 The case of Mali

The Center for Reproductive Rights (2003) highlights the marginalization that women go through in Mali and other African countries. It is stresses that this oppression is supported and at times instituted by formal laws and policies. Often, these oppressive societies are intent on controlling women's sexual and reproductive lives and this may manifest in harmful practices against women such as female genital mutilation (FGM). According to the Center for Reproductive Rights (2003) the reasoning behind these practices apart from tradition, is to control women's sexual and reproductive lives. Children as young as 7 years of age go through the psychological and physical trauma of such procedures.

These procedures also have great implications for the transmission of HIV/AIDS. Through the use of unsterilized sharp objects, many girls and women continue to be needlessly infected with the HIV virus and or other infections. This causes both physical and psychological damage for many women (Center for Reproductive Rights, 2003; Jackson, 2002).

The discrimination that exists against women in many African countries impacts profoundly on availability and access to health services for women. According to the Center For Reproductive Rights (2003) one of those crucial areas is maternal mortality. In Mali the rate at which women die as a result of pregnancy is inordinately high. Every year 1 in 16 women die as a result of complications arising from child birth or pregnancy compared to 1 in 2000 for women in Europe (Center for Reproductive Rights). These are statistics that can be generalized to most sub-Sahara African countries which are the least developed (UNICEF, 2003).

The Center For Reproductive Rights (2003) links the dynamics that pressure women in Mali into unplanned pregnancy with poor pre-and post natal care as factors contributing to maternal mortality. As it is in many African societies, there is enormous societal pressure for women to bear children. Furthermore, the choice to have sex or children is a decision taken solely by the husband. The more children a woman has the more she is seen as fulfilling her expected role. This kind of pressure, and the poor access to and facilities for women's health, becomes an almost certain formula for HIV/AIDS infection and maternal mortality.

2.4.3 Lesotho family law and culture

In many countries in sub-Sahara Africa, as noted by Baylies (2000), women are still legally considered as minors or they have only recently attained the status of an adult. Often, women are unable to make certain decisions without having written or spoken permission from their husbands. In terms of laws of inheritance women are still discriminated against, for example women do not inherit property and are unlikely to be

able to challenge this because of prevailing laws and limited access to legal advice. Pule and Matlosa (2000) draw attention to the many ways in which women have been marginalized in a country like Lesotho. The authors note that since colonial times Basotho women have suffered legal inequalities which placed them in a low status in society. As early as 1915, the then British colonial government passed an act prohibiting the migration of women without the consent of a husband, father or a natural guardian (Pule and Matlosa, 2000). In itself this act placed women in a subordinate position to men. Many decades later, after the fall of colonial governments, discriminatory laws were put into place:

> Not so long ago, the customary law and common law in Lesotho provided legal and social justification for the configuration of power where women are minors thus curtailing their rights and social mobility… women's access to all assets including fields, homesteads, property, and cash is through men… under customary law, a woman is considered a perpetual minor (Pule and Matlosa, 2000:14).

Even when the laws of a country have changed the status of women, it takes a very long time and an enormous amount of advocacy work for traditional beliefs and practices to change at grassroots levels (Letuka et al. 1998). Pule and Matlosa (2000:14) citing Kimane (1985) assert that men are still considered the final decision makers in the home. There is a "patriarchal ideology that is so deeply entrenched in Basotho as a society that women's self concept, their attitudes and values continue to embrace and reproduce the very ideology that perpetuates their subjugation and often misuse". As a result of such power relations women are often limited in protecting themselves within and outside the family, where such protection could prevent HIV/AIDS infection (Baylies, 2000).

According to Letuka et al. (1998) the law in Lesotho recognizes two types of marriages, marriage under customary law and marriage under common law. For both types of marriages, the woman inevitably becomes a minor, whether she is treated that way or not. She is not permitted to enter into any legal dealings without the consent or assistance of

her husband. Paradoxically, women who are divorced, widowed or single exercise more personal freedom in comparison to married women, although their social standing is less.

Murray (1981) observed that Basotho culture has for a long time concentrated around the family unit. Boys were seen as having the potential to provide the household with financial resources, through migrant labour, whilst girls contributed to resources by getting married in exchange for bride wealth (Murray, 1981). Thus, as Murray (1981: 149) states: "A married woman is the focal point of house [sic] identity. However, as daughter to one family and daughter-in-law to another, she also is 'marginal' in respect of her status within both". Within the family context, women tend to have a lower standing than men, the mere fact of being female is likely to put them at the bottom of the family structure (Letuka et al. 1998). Women are seen as weak and not having the mental capacity to make decisions (Murray, 1981 and Letsela, 2001). Letuka et al. (1997) suggest that because of this, Basotho women's self image is poor and limits their ability to take up leadership roles. This image is rooted in traditional stereotypes and attitudes held by both men and women.

Letsela (2001) suggests that gender stereotypical socialization is established at home, in school and other institutions. Kimane et al. (1999) cited in Letsela (2001) emphasize that Sesotho idioms and proverbs are used to reinforce gender role socialization. Letsela (2001) found in her study that English and Sesotho texts in primary schools perpetuate a lack of autonomy for women. Marriage is still seen to be as crucial to a woman's role today as it was in the past. Culturally women are generally restricted to "the home as household managers", and their "career choice" is often limited to that of family nurturers (Letuka et al. 1997; 22). This is not a criticism of marriage and its role in the culture as this would be fruitless and in addition simplistic understandings of contexts within which women are disempowered are also unhelpful. Rather these observations seek to highlight the vulnerability of young women and the lack of protection offered to them by law or custom. Marriage itself is not the problem; the problem is the lack of preparation that young people, especially young women are facing in their quest for marriage and or a family (Motlomelo and Sebatane 1999). Traditional structures that were entrenched in the

culture to guide and instruct young people into adulthood and marriage barely exist and nothing has replaced them. Kimane (1981) also notes that religiosity has also declined with migrancy bringing values that are unclear for young people in a society still steeped in deep cultural beliefs, myths and stereotypes.

2.4.4 Summary

Patriarchy in African societies often leaves women at a disadvantage because it denies them access to resources such as land and money and also denies women decision making power about their bodies. In countries where such a denial of rights has been entrenched in the law, it adds a burden of advocacy work once those laws have been amended. Young women are particularly vulnerable as they are socialized to be future mothers and wives but are given no guidance and protection in these roles.

2.5 Gender based Violence

World wide women share to some degree a subordinate position in their societies. This subordinate position exposes many women to poverty, violence, rape and prostitution (Farmer, 1996). Violence has been shown to be of particular concern in sexual relationships for women, particularly in Africa (Shefer et al. 2000; Wood et al. 1998). It puts women in a vulnerable position to being infected with HIV/AIDS because of their inability to protect themselves. Some situations are specific to certain countries, such as the selling of young women and girls into prostitution (Beyrer, 2001). Furthermore, violence and sexual violence against women and girls under conflict conditions have been under researched and under publicized. In conflict areas in Africa, such as Rwanda and Burundi as well as other regions like East Asia, India and Nepal and former Eastern bloc countries, women have experienced violent rapes on a massive scale and are thus extremely vulnerable to HIV/AIDS infection as a result of gender based violence (Farmer, 1996; Beyrer, 2001).

2.5.1 Definition

The World Report on Violence and Health (2002: 149) defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work". The report views force or coercion on a continuum, from 'pleading' for sex, to psychological intimidation, to using physical force or the promise of financial reward. According to the World Report on Violence and Health (2002), sexual violence against women is widespread across the world, especially against adolescents, and in many countries, up to a third of adolescent girls report their first sexual encounter to have been through force.

2.5.2 Sexual violence in Southern Africa

Wood et al. (1996) conducted a study among Xhosa adolescents that highlighted violence in young women's romantic relationships. Wood et al. (1998) and Shefer et al. (2000) maintain that violence in the sexual relationships of women, particularly young adolescent girls, is significantly high. Most girls are forced into sex through beatings, intimidation and threats, however, on a more subtle level they are also pressured into sex and pleading is also used. Love is also constructed by male partners who suggest that love is shown by having sex (Wood et al. 1996). Wood et al. note that the experience of violence in the lives of adolescents is so endemic that some young girls equated love and intimacy with violence. Motlomelo and Sebatane (1999) also found that many adolescent girls in Lesotho are tricked and coerced into sex. Most young women feel so disempowered that silence becomes their main way of dealing with the violent circumstances, especially because silence is a solution often encouraged by their peers (Wood et al. 1996).

2.6 Considerations on prevention efforts

The biomedical approach to research into lowering the spread of HIV/AIDS has focused on individual factors such as reducing high risk sexual practices (Giffin and Lowndes, 1999). This has resulted in the development of intervention programmes only geared towards advising people to decrease the number of sexual partners and using condoms consistently. This approach alone has done little in reducing the spread of HIV/AIDS in Africa.

Giffin and Lowndes (1999) point to the important fact that HIV/AIDS prevention proposals are perplexingly silent on the fact that condoms prevent conception which does not address the needs of those who wish to fall pregnant. Kouadio (1999) notes that HIV positive people of both sexes still want to have children, however there is a lack of information for them as to how this can be done in a way that can reduce the risk of infection or re-infection for a couple. It is also noted that research that looks at understanding experiences of sexual behaviour within a context of loving relations has been largely neglected (Giffin and Lowndes 1999).

There is also great concentration in prevention efforts on empowering girls and women with skills to negotiate condom use with partners. These efforts fail to consider the cultural, economic and political contexts within which these girls and women are expected to engage in such negotiation. The question still remains whether such skills training will counter deeply entrenched, cultural patriarchal beliefs. Furthermore, given the scarcity of resources (as discussed in the section dealing with poverty) it is unlikely that such training will reach those most affected and at risk. It is clear that a great deal more has to be done in order to implement effective and widespread prevention programmes.

Researchers and prevention programs have also largely ignored one of the most crucial factors, from a gender perspective, which is the differences that exists in both values and

practices related to sexuality between men and women. Importantly, research suggests that women value the affective relational context of sexuality (Giffin and Lowndes, 1999). Giffin and Lowndes (1999) suggest that:

> gender sensitive analysis now requires going beyond the notion of empowerment for condom use but to consider prevention in the context of ongoing affective reproductive relationships in such a manner as to take into account the significance of these relationships and the sexual values which women are expressing. (p.284)

Giffin and Lowndes (1999) conclude that research that continues to devalue women's beliefs and values contribute to the reproduction of male oriented conceptions of sexuality and women continue to be increasingly vulnerable to AIDS.

In complex contexts where culture and poverty are endemic there needs to be a variety of options and approaches to HIV/AIDS prevention. Researchers have pointed out that religiosity is a protective factor for young people both in preventing high risk behaviour generally but also in preventing early sexual relations (Moore and Rosenthal, 1998) as well as decreasing high risk sexual behaviour among young women (McCree, Wingwood, DiClemente, Davis and Harrington (2003). However McCree et al. (2003) also note that little research has been done in this area. This may also explain the slow way that religious organizations have responded to the HIV/AIDS pandemic, that is their lack of involvement in HIV/AIDS prevention efforts. The tension and conflict that exist between society and churches, in general, with either side focusing on the disadvantages of the others approaches, has meant a lack of an integrated approach to HIV/AIDS prevention between these important and influential structures.

2.7 Conclusion

In conclusion, research shows that young African women are most vulnerable as a group to the infection of HIV/AIDS. The period of adolescence as it interacts with gender relations, poverty and culture is an important consideration in the understanding of this vulnerability. Localized research is clearly crucial in understanding the impact of poverty and culture on the health of young people. Such research helps to clarify the nuances of specific contexts and individual cultures; and the nature of gender relations in the context of sub-Saharan Africa. The nature of gender inequalities in the sub-Saharan African region, in particular, Lesotho, have grave consequences for the health of young people and women in general. Prevention efforts need to take cognizance of particular issues, such as the violence that young women in sub-Sahara Africa are exposed to.

CHAPTER THREE

3. METHODOLOGY

3.1 Introduction

This chapter begins by looking at the reasons that brought the researcher to use a qualitative approach to the study. This is followed by a discussion of the use of interviews as a research tool. It then outlines the research design and a description of the sampling, data collection and methodology followed by a brief discussion of ethical considerations informing the research.

3.2. Locating the study within the qualitative methodological paradigm

According to Babbie and Mouton (2001) qualitative methods are useful in that they attempt to understand behaviour and feelings in terms of the individual's own beliefs, history and context. The authors note that qualitative approaches have their roots in metatheories such as phenomenology and social interactionism, theories which emphasize the importance of the individual's own sense of being in the world as well as his or her social context (Babbie and Mouton, 2001). The aim of this study is to explore, describe and understand initial sexual experiences of young Basotho women. This is in keeping with some of the goals of the qualitative approaches that are described by Babbie and Mouton (2001).

Wood et al., (1998) make the important observation that numerous studies have shown that there is variation in female sexual empowerment in various contexts and this leads to the need for specific, detailed situational analysis. This has important implications for health prevention programs in that they would benefit from being guided by localized analysis for them to be locally relevant and effective. Thus Wood et al. (1998) cite (the AIDS and Reproductive Health Network in Brazil, 1995) to highlight that, strategies for health prevention tailored for women whose conditions offer them empowerment

economically, socially and culturally ought to differ from the ones for women whose situations are violent and oppressive.

The researcher wished to develop a localized and contextually sensitive understanding of the interface between the issues highlighted in the literature linking the HIV/AIDS pandemic with gender, poverty and violence and the narratives of six young women living in Maseru, Lesotho. The qualitative approach was appropriate to such research, which hopes to elucidate both the individual's perceptions and experiences, and the context within which research participants live. According to Neumann (2000) appreciating the context of the object of a study is an intrinsic aspect of qualitative research. Furthermore the material that emerges from the data collected may inform the development of theory. Another important reason for adopting this approach is that the researcher needed to keep an open mind to emerging data. According to Krathwohl (1998) the qualitative approach is very creative and allows for the generation of new hypotheses and ideas to emerge through an open dialogue between researcher and interviewee.

3.2.1 The interview as a qualitative research tool

According to Krathwohl (1998) the interview is one of the most commonly used methods of gathering data in qualitative approaches. This is because it is very useful in allowing a researcher to explore, probe and search to get at the information needed and to uncover information that was not anticipated. The interview is also important in that, it allows for an establishment of a relationship between the researcher and respondent (Miller and Glassner, 1997). Interviewing is a commonly used technique across a number of contexts. Krathwohl emphasizes essential attributes of the interview in this way:

> Wherever there is a desire to tap an internal process, to gain knowledge of a person's perceptions, feelings, or emotions, or to study a complex individual or social behaviour, some form of interviewing is most helpful (1998:286).

This study used what Krathwohl (1998) describes as the 'focused interview' conceptualized by Merton, Fiske and Kendall (1956, in Krathwohl, 1998). It allows for exploration while still enabling the researcher to get at specific information in the same sitting. Kvale (1996: 70) reiterates that the "qualitative interview is a uniquely sensitive and powerful method for capturing the experiences and lived meanings of the subject's everyday world". Both Miller and Glassner (1997) and Mishler (1986) suggest that interviewing is a complex process that ought to be understood as jointly produced discourse. In itself, interviewing is not just about the interviewer asking for information and the interviewee providing that information, it is about both agreeing on the meaning of their speech interaction. According to Rubin and Rubin (1995) the interviewing process is also greatly enhanced by rapport which allows respondents to trust the interviewer and speak about issues they would probably only speak about to friends and family.

Being a young Mosotho (Mosotho is a singular noun describing a person originating in Lesotho) woman myself and sharing a common language with the respondents facilitated good rapport and trust between us. Language commonality also enhances the interview process because one is able to pick up on and understand subtle nuances of the particular language. Swartz, Drennan and Crawford (1997: 168) stress that "Language is not however simply an implement or tool, but it instead represents an embodiment of culture and identity. It mediates and creates relationship amongst people". There may nevertheless also be a limitation in sharing a common language in a research context. There can be an assumption of commonality in experience and meaning in what is said between myself and the interviewees. An assumption which Mishler (1986) cautions interviewers about because the nature of the interview is that there is an ambiguity that often comes with the meaning of questions and responses. Interviewers need to be aware of this and treat the interview situation with appropriate attempts at negotiation of meaning in order to resolve it (Mishler, 1986).

Reformulating and re-framing the communication to reach a common understanding begins prior to the interview, through all other preliminary interchanges. Mishler (1986)

describes this as an internal history of the developing discourse. According to Mishler (1986) mutual meaning is often reached after the formulating and reformulating of interchanges between interviewer and respondent, and the relevance and appropriateness of questions is realized within the discourse itself. Kvale (1996) takes this point even further and highlights the importance of a skilled interviewer. Such skills include knowing when to let a respondent lead the interview when addressing sensitive issues (Owens, 1996). It is hoped that my training in Clinical Psychology enabled me to listen and to probe the experiences of participants with empathy and a non-judgmental attitude, which would facilitate open dialogue about a sensitive topic.

3.2.2 Limitations of the semi- structured interviews

Unlike unstructured interviews which allow the participants to direct the conversation more freely, a semi-structured interview is restrictive and dictates to a degree what the participant is able to talk about. The interviewer is more or less controlling the direction of the conversation and probing areas which are of interest to the interviewer and is informed by the interviewer's perspective rather than that of the respondent (Corbin and Morse, 2003). This restriction runs the risk of the interviewer controlling the interview situation entirely where the interviewee may feel disempowered similar to a situation of a doctor and patient interview, where the doctor's power is evident in the interview (Mishler, 1986). It is hoped that an awareness of this danger and the clinical skills referred to earlier would have limited this imbalance to some degree.

3.3 Research design

The research question and interview questions arose out of an initial set of pilot interviews. These first interviews were with participants recruited through convenience sampling. These initial interviews were useful in helping the study to become more focused and polishing the interview skills of the researcher in the context of research interviews. Rubin and Rubin (1995) encourage similar exercises to get the practice of interviewing in a research context. A semi-structured interview schedule was developed

and used in the interview to guide the discussion and to allow for relevant issues to emerge. The pilot interview schedule also helped to refine the questions which would be used in the research itself. The questions arose out of themes which were viewed as central in the literature reviewed in Chapter Two and on the basis of issues pertinent and relevant to the broad context within which the participants were living. The semi-structured interview schedule also allows for a shaping of the interview and focuses discussion around key areas. In addition the structure helped the respondents to make sense of their experiences for themselves and informed them of the aims and interests of the researcher (Corbin and Morse, 2003).

Following the pilot interviews and discussions with colleagues, key themes were identified and informed the content of the questions asked in the semi-structured interview schedule.

The themes were as follows:

- Attraction- what was the attraction to the boyfriend
- The first sexual encounter- this included age of the participant and the partner.
- How the situation came about.
- The emotional response- feelings during and after the encounter
- Exploration of forced sex
- Knowledge about sex- where they got to hear about sex and how much they felt they knew about it at the time.
- Knowledge about STIs and HIV/AIDS
- Attitudes toward family planning clinics

The question guide also included a section on demographic data, which explored among others things, level of education and financial status. The researcher did not use a systematic assessment of financial status. The assessment came mostly from the participants describing their means of financial resources in their families and describing whether they subjectively felt they were struggling financially. See Appendix 1 for an outline of the semi-structured interview schedule, including the demographic section.

3.4. Research participants

I decided to use purposive sampling; selecting a sample based on what the researcher knows about the population, its elements in conjunction with the nature of the research aims (Babbie and Mouton, 2001). The researcher relied on the availability of the subjects and their willingness to volunteer. I chose to interview six Basotho females ranging in age from 16 to 24. I chose this age range as older adolescents are likely to be more open to talk about sensitive issues such as sexual experiences. The United Nations Population Fund defines adolescence as the age between 10 and 19, youth as ranging between 15 and 24 and young people as those between the ages10 and 24. In this study all three terms are used interchangeably to include all the above age groups. Harrison et al. (2001) note that younger adolescents are less likely to feel free to talk about difficult topics in one on one interviews and that is why I chose this older age range, also because they were likely to be sexually active. Of the six interviewees, four were volunteers who attended the adolescent health service center (see chapter one) and had volunteered after the nursing Sister and the researcher had introduced the research aims of the researcher. The remaining two interviewees were from a village in the Maseru district, highly underdeveloped in terms of access to water, schools and the other services.

3.4.1 Gaining entry

I grew up in Maseru and thus felt familiar with the area and its cultural context. My access to interviews was informed by my own identity. Nonetheless access still had to be mediated through known and trusted "others".

In this study, access to four of the adolescents was negotiated through nursing Sister at the adolescent service center. The nursing Sister and I were colleagues working in the Ministry of Health; I was interested in the unit she is working in. In August 2002, I met the nursing sister and in conversation informally introduced the idea of the utilizing the unit for the study. She warmly encouraged my interest in the unit long before I was able to do the interviews.

I then visited the unit to get acquainted. It was a brief visit to formally enlist her help and to brief her on the study. There were months when she was working night shift and I determined to only go there when she was available as I felt comfortable with her. I later paid another visit to the unit and she was able to give me a description of the services offered and guided me to where I was to go for the permission to carry out the interviews.

Once I had received the letter permitting me to carry out the interviews (see Appendix 2), I arranged to visit the unit to meet possible interviewees. After the Sister had given the educational talk for that day on reproductive health and nutrition, she introduced me to the group of approximately 20 young women who were present. She explained who I was and gave me an opportunity to explain about the study, how interviews would be conducted and to address the issues of confidentiality. This helped create a level of trust which was evident when hands shot up when the Sister tentatively asked who was interested. The young women asked questions about confidentiality, some wondered whether their voices would be heard on the radio and I was able to reassure them that confidentiality would be maintained.

In the Sister's introduction she explained the usefulness of research to the group by highlighting that the reason adolescents have their own services separate from adults was because someone had done investigations like I was doing. The Sister indicated that we were colleagues which in conjunction with her introduction of me to the group helped facilitate the establishment of trust since she was already trusted by the young women she was introducing me to.

This can be contrasted with my experience at the center the following day. Due to the failure of the recording equipment in one of the interviews I returned the following day to the health service center for one more participant. This time the Sister was occupied with clinical work and unable to speak on my behalf. Only one woman volunteered but it was conditional on her husband's willingness to wait for her when he arrived. Outside I had noticed one of my previous interviewees and she had told me that she had brought a

friend who was waiting for her. I went to her and explained my predicament. She spoke to her friend on my behalf and the young woman agreed. Clearly access is a complex and delicate issue, greatly helped if the researcher can be introduced to the target group by someone known and trusted by the group. Schutt (2004) stresses the importance of honesty about encountering problems in the research process and giving an informative account of how they are resolved, this enhances validity and becomes a learning experience for the researcher and the reader.

With the two participants from the village I enlisted the help of a go between, in this case a family friend. This village was familiar to me as I have relatives in the area. We went about searching for adolescents she was familiar with. Having this individual with me helped a great deal. The first two adolescents we approached declined to participate, with them she had left it to me to explain my research, although I was familiar with the village, I was still a stranger. I then explained to my go between that I thought the young women would feel more at ease if she introduced me and gave a little explanation on my behalf. In the next interaction there was a noticeable shift and the two young women were agreeable to be interviewed.

3.5 Data collection

The interviews in the Unit were conducted in a private office not far from the center; the interviews were conducted on the 7th, 9th and 10th of October, 2003. The interviews took about an hour each and were conducted exclusively in Sesotho. The interviews of the two participants in the village were conducted under a tree at the back of the home of one of the participants. In one interview the interviewee had her toddler with her for part of the interview before her grandmother came and took the toddler. The semi-structured interview schedule was used with caution and particular attention was paid to the flow of the interview and the order of questions was not followed strictly. Rather the schedule was used more as a prompt to guide the interview and to remind the interviewer of important themes to explore. All the interviews were tape recorded and labeled.

3.6 Data analysis

The recorded interviews were listened to and re-listened to and transcribed and translated from Sesotho into English. Mishler (1986) and Tilley (2003) make the important observation that the process of analysis and a gaining of a deeper understanding of material is derived from the process of constructing a transcript through listening and re-listening. The process of transcribing and translating was long and complex. Swartz (1998) stresses the complexity of translation, which involves conceptually translating the meaning of the word as well as finding the linguistic equivalent of the word or phrase. In this research direct translation would have in many cases meant losing actual meaning in the Sesotho language and so I used my knowledge of both languages to translate the actual meaning into English. Linguistic flow was not easy to attain as sometimes direct translation sounded ungrammatical. There was also layered meanings to words, for example, 'ho tiisa' means to strengthen or tighten but is also used to denote a civil marriage. I also enlisted the help of a Mosotho friend checking meaning and word equivalent, she is a high school English teacher and a fellow master's student in education.

I studied the transcripts and identified emerging themes through coding sentences and paragraphs, a process outlined by Strauss and Corbin (1990) cited by Babbie and Mouton (2001). According to Tilley (2003) the process of transcribing and reading transcript material, that is, the researcher immersing him/herself in the data is a necessary one in order allow the data to speak for itself. Tilley (2003) emphasizes the point that transcription on its own is a methodological process which is quite complex. Nevertheless, although transcription is an explicit process, a transcript is never a truthful replication of objective reality. Mishler (1986) adds that a transcript is only a partial representation of what occurred. The end product is often a construction of data by the researcher for a specific purpose. When the interviews are directly quoted in the text, their words are recorded verbatim and without grammatical or stylistic corrections.

On reflecting on the data and the whole process of research, I am aware that my interest in the research topic is indicative of my own personal need to do something about the HIV/AIDS pandemic that is tragically affecting a group that I belong to, being a young African woman. The methodological approach and themes that were viewed as significant reflect my need to put faces and stories to the overwhelming statistics presented to us by quantitative research. This need will inform how I 'hear' and 'interpret' the interviews and the naming of emergent themes will be affected by this. Nonetheless it is hoped that the interviews and the analysis thereof will offer some insight into ways in which the HIV/AIDS pandemic may be understood and addressed among young women in Maseru.

3.7 Ethical considerations

One of the most crucial issues in research interviews is that of confidentiality (Corbin and Morse 2003). Corbin and Morse (2003) note that, very often in interviews, respondents are revealing intimate and private material. In this particular study, the researcher went to great lengths in explaining to the participants the aims of the research and how confidentiality would be assured. I also stressed the importance of interviewees feeling safe and able to trust the interview process. Corbin and Morse (2003) explain that phase one of interviews is characterized by repeating information about confidentiality. When I met with the interviewees in private I repeated explanations to participants individually explaining that their names will not be used and the research will be written in such a way that their identities will be concealed. Corbin and Morse (2003) add that the risk of a breach of confidentiality can be reduced by being careful in handling records as well as concealing identifying information. In order to do this the interviewee and I came up with the pseudonym.

In addition to the issue of confidentiality, Corbin and Morse (2003) highlight that often topics that are dealt with are sensitive and may evoke intense emotions for the individuals being interviewed. This may leave interviewees feeling uncontained and emotionally vulnerable. However the authors also point out that participants in qualitative research

generally have a great deal of power as to what they say and how much they say. The researcher, being aware of the private and sensitive nature of the topic of the study, alerted and informed the participants of this before beginning the interviews and asked participants at the start of the interview whether they still wished to continue with the interview. As pointed out earlier I also hoped that my clinical training would provide some containment and empathic management of the interviews. Corbin and Morse (2003) note that respondents often find the research interview a rewarding experience. Some of the respondents expressed this sentiment. One interviewee expressed interest in seeing a copy of the final research report and was assured that this would be made available to her. In addition the Adolescent service center and the Ministry of Health were also assured of receiving copies of the final report.

3.8. Conclusion

In summary, the qualitative approach was seen to be most suited to and in keeping with the aim of the study; to produce localized and contextual information on young Basotho women's experiences and understanding of their sexual relations. The interview is a theoretically sound and practical tool that has hopefully enabled the voices of these young women to find expression. Both the qualitative approach and the semi-structured interview as a tool lend themselves to the exploration of a sensitive topic and private material which can, hopefully, be examined in useful manner that may contribute to the struggle to understand the HIV/AIDS pandemic and how best to intervene.

CHAPTER FOUR

4. RESULTS

4.1 Introduction

This section presents the results from the interviews. The first section outlines the demographic details of the participants including age of first sexual encounter. The next section outlines key themes that emerged from the data. As much as possible direct quotations are used so as to let the young women speak for themselves.

4.2 Interviewees' demographic details

Bonesoa is 16, single, and still early in her pregnancy. She is under the care of her recently widowed father. She has Form C level education, equivalent to grade 10 and lives in a rural setting. She admitted to struggling financially to a point where there is no food in the home and they have to go asking their neighbours for food. She was raped at the age of 13 and did not tell anyone until recently at age 16. Her first consensual sexual encounter was at 14.

Thandi is 18, married and early in her pregnancy. She has a grade eight education, both she and her husband work. She is a factory worker and his income is not consistent. They live in a rural setting and struggle for money though she feels it is not so hard. Her first sexual encounter was at 14.

Zanele is 20, single and has a grade 10 education. She has a two year old. She lives with her mother and older sister. They struggle financially although not all the time. They sometimes struggle for paraffin (mainly used as fuel for cooking). She also dropped out of school when she got pregnant and has been unable to go back due to financial constraints. She was raped by her first boyfriend at the age of 14.

Lucy is 24 years old, single and has one child. She has a grade 12 education and works as a teacher. She lives with grandmother, three siblings and two cousins. Her situation is financially less desperate than the other participants. She had her first sexual encounter at age 18.

Sibongile is 18, single and is advanced in her pregnancy. She has a grade seven education. She lives with her mother and three siblings. Financially, her family is coping and her mother is able to keep all the children in school. She had her first sexual encounter at the age 17.

Bongiwe is 18, though petite and looks a great deal younger than her chronological age, single, and she has a grade six education. She is not in school because she is unable to pay the school fees, previously an uncle was paying her fees. She lives with her mother who is a domestic worker and an older brother who was recently in jail. They often struggle for food. She had her first sexual encounter at the age of 16. She had been brought to the clinic by one of the participants.

4.3 Key themes arising out of the interviews

This section is divided into three main themes: what attracted the girls to their partners, what factors contributed toward the relationship becoming sexual, and what risks were associated with their first sexual interaction. The first theme focuses on what attracted the young women to their first boyfriend. This is followed by an exploration of the main reasons given by the interviewees for why they engaged in their first sexual interaction. The interviews suggested the following main themes: the belief that sex would strengthen the love between the young girl and her partner, that partners pressured or coerced the girls into having sex with them and that if there was a choice for the girl she was influenced by the opinions and expectations of peers and older siblings. Finally the risks which these young girls associated with their first sexual encounters were related to risk of pregnancy, being 'spoilt' and some limited concerns about sexually transmitted infections. Perception of risk and knowledge about STIs also form part of this section.

4.3.1 What attracted these young women to the partner with whom they first had sex

Whilst the young women reported a variety of attributes which had attracted them to their boyfriends, four commented on their boyfriend's personality and looks. Bonesoa regarded her boyfriend as someone who was responsible, obedient and diligent; able to work in the garden and committed to his education like she was:

> Bonesoa: It's perhaps when I used to hear and I used to love it when they at his home used to comment that he is a good child, all the time when he wakes up he goes to the garden or goes to school. So I was happy because I also used to do that at my home, this is the person we could strengthen it together with and then I found myself loving him very much [laughs] yes.

Thandi thought her potential suitor was handsome and in addition well behaved and unique, unlikely to be easily influenced by other boys.

> Thandi: In him its like what attracted me to him is that I just saw him to be a person, like a guy I just liked [she laughs] [I interrupt]
> I: Mh what was it, you didn't like them all did you?
> Thandi: It's like he was a person who was conscientious, who does not go to many things or be with those kind of people, it could happen that you find young men sitting and talking about girls, you would find him to be a person walking alone just…
> I: Just walking alone by himself?
> Thandi: Like he would not be sitting with the others in those things… [she laughs] Oh ok shall I explain now?
> I: Mhmm was there something else that attracted you to him?
> Thandi: You see he was a handsome person so [maybe] I was in love with his handsome looks.

For Lucy, it was a relationship that grew out of friendship. It was the way they related with each other which led them into a relationship.

> Lucy: There was nothing that really attracted me that much, its just that he used to understand me and we used to talk a lot about everything, like when he had problems he used to tell me and when I also had problems I would tell him and we would solve our problems, there was nothing that was personal that attracted him to me at all, it wasn't there…it is only that we used to talk to each other and then he used to help me somewhere, somewhere.

With these young women there is an absence of choice based on possible financial reward or income which is so commonly attributed to young women in such contexts. There is instead a sense that they felt they shared common values and a sense of being understood by their potential partners.

4.3.2 Factors which contributed toward the relationship becoming sexual

This section presents the themes that illustrate the internal and external factors that led these young women to have sex.

4.3.2.1 Sexual intimacy as a way of strengthening love

In the interviews it became clear that sex for these adolescents was a way of solidifying their relationships. The young women related to sex as part of an affective expression that affects their relationships in a positive way. Bonesoa suggested that sex strengths love or a relationship:

> Bonesoa: I was loving him since we were young, growing up but we had not done anything big until we found ourselves grown. When I came back [Bonesoa had been attending school in South Africa for several years], my father and everyone were telling me, this is the person you belong to, even we

knew it. That is when we found ourselves saying we are strengthening, we are doing like the adults…It is like we were strengthening, like perhaps, its like we have heard it said that when you have had sex with a person, you love each other very much so we also had sex thinking that it will also be like that.

Some of the young women felt that their feelings had indeed grown stronger after they had had sex. This is despite the fact that all of them had not enjoyed their first encounter, a theme that is discussed later in the chapter. Thandi spoke about her first encounter as painful and scary. However when asked about her feelings about her partner at the time she maintains a deeper love for him:

Thandi: Well I felt that he is a person I can go far with [laugh]
I: You felt that you loved him more?
Thandi: Yeah, I really felt that that is where I found life, I can say and the warmth of love.

Having sex with their boyfriends meant that they had found and shown love. There does not appear to be a distinction between expressing affection and sex in their minds. Their choice to have sex was also strongly influenced by the pressure placed on the young women to have sex by their boyfriends, who at times used the argument of 'If you loved me enough you would have sex with me'

4.3.2.2 Partners pleading and pressurizing the young women to have sex with them

Perhaps with the exception of Bonesoa, the young women share a common experience of being pressured to have sex by their partners. All the respondents reported that it was always the boyfriend who brought up sex, asked for sex and appeared determined to get sex. The young women expressed feeling pressured into having sex; they did not have the first sexual encounter because they felt ready to, they had it because the boyfriend wanted to have sex. Below are some excerpts of how some of the participants explained what happened:

I: Do you still remember what happened?

Sibongile: When I ended up sleeping with him?

I: Yes

Sibongile: Aah well, I had visited him and having visited him we were just chatting and then he said I should kiss him, that is where it started and then he said that he is asking that we should sleep together and I did refuse and until I found myself having slept with him.

Thandi: It's like he was someone who was always asking but I couldn't because I was always feeling afraid. I don't know what it was that gave me the spirit for it to happen…when I refused he would seem like a person who is still satisfied [pleased] in his heart but he was a pleading person I can say.

I: So when you look back now what would you say led you to end up having sex?

Thandi: What made me end up agreeing…you see, I could see that he is not satisfied anymore.

Lucy used her wish to be educated as a way to argue against the pressure and pleading from her boyfriend. Lucy's boyfriend suggested despite the fact that they had been going out together for a couple of years because they had not had sex he did not in fact 'know her'. Whatever the rationale used by the boyfriend the young woman must defend herself through counter argument or relent to the pressure to have sex:

Lucy: He was someone who wanted us to have sex , you see, so I would tell him no because I want to write, I don't want to get into those things of sex that much… he used to ask me nicely, "Ok Lucy, I am sure that we have been together this long time and I haven't slept with you, I haven't known you, so I need to know you"

Lucy was able to delay their sexual encounter until she had completed her grade 10, thereafter she felt she must concede as that was the 'agreement' they had reached. Unlike Lucy, Bongiwe did not have much in the way of countering her boyfriend's argument for why they have sex. Bongiwe had initially refused and in response her boyfriend had suggested that love is expressed through sex. Bongiwe seemed persuaded to some degree by this argument and she also felt that his needs and wants were more important than hers. She wanted to make him happy even if it meant doing something she was not ready to do. His accusation that she was not demonstrating her love to him by having sex with him was a challenge which Bongiwe found difficult to counter, since it suggested that she was failing him:

> Bongiwe: Yes we used to talk about it, he would tell me and then I would refuse.
> I: What would he say?
> Bongiwe: He would say he is asking please can we sleep together and then I would refuse because at home I was told not to have sex.
> I: So you would refuse when he asked you to sleep together, until..?
> Bongiwe: Until one day when he said that we should sleep and I agreed, he said to me it looks as if I don't love him, but I said no, I said that I am trying to satisfy him.

Zanele illustrated other means by which her boyfriend argued that sex was desirable or necessary. Her boyfriend suggested to her that if she did not have sex with him she was being childish. At a stage where young people are struggling with feelings of wanting to be an adult and knowing that one is no longer quite a child, this becomes a subtle but powerful argument to use, as the young woman may feel pushed to prove that she is no longer a child:

> I: That first time when he spoke about those matters, how did he bring it up?

Zanele: He just said to me I should visit him and I just said I should visit him going to do what, then he said I am now old, I am not supposed to be asking him those kind of questions.

The arguments of persuasion used by these young women's boyfriends raise a difficult issue in terms of the coercive nature of these first sexual encounters for these young women. It was clear that the interviewees were often unable to argue against the logic of the reasons their boyfriends gave them for why they should have sex with them, as any arguing against was countered within a framework in which the young women's love, commitment or maturity was called into question. Zanele expresses this dilemma most poignantly when she struggles to describe what she experienced with her boyfriend. Throughout the interview, Zanele used the word force for an event which would be usually described as rape. I wished to clarify how she understood her first sexual encounter and following emerged:

I: I don't know, tell me if I am not understanding or taking this the way you are, do you believe that he had raped you or he had **just** [my emphasis] forced you?
Zanele: Well I believe he **just** [my emphasis] forced me.
I: Why?
Zanele: Because maybe he just wanted to satisfy himself.
I: What do you see to be the difference between a person who is raped and one who is forced?
Zanele: I haven't seen any difference, it's because when you are going out with someone it is difficult for you to say that he has raped you.

In essence rape is impossible if you are going out with someone. It seems that once involved as boyfriend and girlfriend there is already an unwritten code of conduct which requires that sex will happen and what young women are most likely able to do is delay that event but not stop it. When it does happen against that young woman's wishes it is 'just force' but not rape.

4.3.2.3 Influence from peers and older siblings

From the interviews it became clear that peers and siblings were a source of information about sex and also influenced these young women's attitudes towards sex. Peers and siblings provided information in relation to sexuality which the adolescent girl is likely to be curious about and in this context is likely to have limited access to as will be discussed later. Peers and siblings also model what is desirable and normal in terms of sexual behaviour for these young girls. Bonesoa expresses how even though she had received warnings about sex, her sister's behaviour influenced her:

> I: So where did you hear this thing?
> Bonesoa: Sex? from school, it would be told that you should not have sex or you will get babies, things, sicknesses not so? Then you would be told but the body has its own desires. Or perhaps sometimes when people are just talking, our older sisters they would be chatting: "No me I was with my boyfriend at so and so and we were doing this." then I decide that I am also doing it…yes I heard it through them when they were chatting with her friends that: "I was with my boyfriend somewhere and so we had sex" and then I myself just took it that I am going to do this which my sister has done to see what it is she got after that.

With Thandi, the 'sister', was a cousin. Basotho often see cousins particularly first cousins as siblings, however, even a friendly neighbour or a sister's friend can be seen as an older sister. The term sister, does not only refer to a blood sibling. We see the example of the kind of influence and to some extent pressure that even a cousin sister can have in this excerpt:

> Thandi: I would always hear older sisters chatting, chatting about these things, so saying to myself, let me also get myself there… there was a lot of it and even the fact that I was still childish [she laughs] now the way I see it, the thing that led me to end up doing it, is sitting with these older sisters, when

they are chatting I am listening…[she laughs] she used to encourage me, again another thing that did, as it is, I attended school already knowing a little bit about life, even though not all that much, she used to tell me that if I sleep with a boy right now, while its still now as I am still young, when I have had some time, that is telling me, to sleep with him, she would just, like. [to interviewer] should I just speak frankly? Not so? [she laughs]

I: Mhmm.

Thandi: Like she would say as I have not yet started menstruating, there can never be the mistake that he spoils [gets you pregnant] you, she said that when I start seeing me go through menstruation, I should try to hold back [behave].

Lucy was the only one of the interviewees who reported that her mother was always talking to her about sex; she felt her mother was very open with her. Nevertheless, the influence of her peers also put pressure on her and this is how she expressed her confusion:

Lucy: Like when I would be sitting with my friends, they would be chatting: 'If you can do this and that you will enjoy.' So the fact that when I was at home I was told this and that, I didn't know who I was going to believe and who I wasn't because I would hear my mother tell me "it's not the right thing"…I felt that my friends, as sometimes it is said a friend can make you fall [lead you astray]…so I thought maybe they are telling the truth or they are not telling the truth, I used to feel ashamed when I got home because I was told.

Thus even when the channels of communication are more open between parent and child with regard to sex and sexual activity, such as was the case with Lucy, the adolescent is still faced with pressure and contradicting information from her boyfriend and peers and older siblings.

4.3.3 Risks associated with the first sexual encounter

This section outlines the worries and fears about the possible consequences that these young women were primarily preoccupied with about having sex and even afterwards.

4.3.3.1 Fear of getting 'spoilt'/ pregnant

All the interviewees expressed their primary concern about their first sexual experience and thereafter as being worried about falling pregnant. The very term used in Sesotho when a girl gets pregnant before marriage is "o senyehile" [She is spoilt], indicating that she is 'damaged'. The consequences of such spoiling are that she is most likely to be abandoned by the partner and possibly punished by her parents. Being spoilt also reduces her chances of getting married, which for most Basotho women means access to financial resources and social capital. Therefore it was pregnancy and its consequences, not the possibility of STIs including HIV/AIDS, which these young women worried most about. Bonesoa had a little information about HIV at the time of her first sexual encounter and she had gotten that info from an HIV positive person who had visited her school. Even with that, what she had worried about at the time had been getting pregnant:

> I: Was there something you worried about after that?
> Bonesoa: The only thing that worried me was getting pregnant or I worried about what if my mother hears that I had had sex, what sort of thing will it be or if his mother heard that we were in her home when we had sex, how will she receive it?

Thandi had worried about getting pregnant and it was the expression of this worry to her boyfriend that allowed for a negotiation for the use of a condom in her first sexual encounter. She feared getting pregnant and her partner had allayed her fears by introducing condom use:

> I: When he used to ask you, what would he say?

> Thandi: What would he say? You see when it comes to the point when he would ask me, I would say to him: 'You see you might just say you have sex with me and then you spoil me [get me pregnant before marriage] and then after that you turn your back on me.' Then he would promise me CDs [condoms] and the likes.

The fear of getting pregnant is so intense in young Basotho women that, after being coerced into sex Zanele was distressed mainly about the possibility of falling pregnant:

> Zanele: My mother told me that I am not supposed to sleep with boys, I will have a baby. So that is what I was afraid of only, because I did not know anything at that time.

It is noteworthy that it is not the coercive circumstances in Zanele's case which preoccupy her and in Bongiwe's case even though there is some knowledge about STIs, in particular HIV/AIDS, the only concern expressed is of the possibility of falling pregnant. Thus despite the life threatening nature of HIV infection, the social context and demands faced by the gendered position young women hold in this society appears to be the only factor which influences the possible use of contraception for these young women. Similarly it was the argument concerning pregnancy which altered the behaviour of Thandi's boyfriend.

4.3.3.2 Shame and guilt and pain

None of these participants reported enjoying their first sexual encounter and all of them in retrospect wish they had waited. Most reported that it was painful and that they had had feelings of shame. Thandi experienced her first sexual encounter as a loss and because of the pain had felt afraid to continue a sexual relationship:

> I: How did you feel after that [the first time]?
> Thandi: Well, because it was my first time I just felt depressed.

I: Depressed or dirty ? [the words have similar sound in Sesotho]
Thandi: Depressed, like I felt afraid to have sex with him again.
I: So it wasn't something enjoyable to you?
Thandi: Mhmm, that first time or maybe its because I did it scared, like what I see is that it was my first time saying I am throwing myself for a boy.

Lucy had managed to make her boyfriend wait until she had written her examinations and she still shared similar feelings of shame and regret:

I: How did you feel after that?
Lucy : Mhmm the fact that you are told that a thing is wrong, you see, I wasn't relaxed that much, I was doing it already scared, I just was not relaxed…and then afterwards I regretted, I am wanting to satisfy another person but I am not wanting to satisfy my parent, you see, it wasn't, I wasn't happy with the situation.

In retrospect, the young women expressed regret over the timing of their first sexual encounter, they felt they had been too young and that they would advise others to refrain until a later stage. They also would advise youth to give having sex serious thought and take more precautions:

Thandi: I think it was not the right time for me, I just hurried, it was just not right for me.
I: What would you say to a youth that age now about sex?
Thandi: You know I would just say they must just try to hold back, try to get to an older age so that they don't become like me.

Zanele felt similarly:

I: A youth that age, how would you advise her?

Zanele: I would advice her not to do sex, even though when you advise them, there are many who I tell right now, you find that they say 'no this one because she is tired, she has made a child she doesn't want us to feel what she was feeling' not knowing that we are advising them because we have passed through those problems.

It is noteworthy that the young women with the exception of Lucy had taken complete responsibility for their first sexual encounter and had not reflected on the pressure from their partners.

4.3.3.3 Lack of knowledge about STIs, HIV/AIDS and prevention

Three of these young women had heard about sexually transmitted infections and HIV/AIDS at the time of their first sexual encounters but their knowledge was limited. They currently held some disturbing misconceptions about prevention methods and modes of infection. They all felt that they did not know much about reproductive health at the time of the first sexual encounter and that they had not acquired much information since then. In terms of the transmission of STIs and HIV/AIDS the interviewees had very limited knowledge. Whilst it was understood that contact was necessary for the spread of infections this included both casual contact and sexual contact:

I: So do you know how one gets infected?
Thandi: AIDS, I don't know but I have heard them say it that one can get infected if we eat from the same dish, what you use if I use it like lets say brushing teeth and so on, so after you brush your teeth I take the thing you brushed with and wash mine, I understand that is how it is infected, even when you sleep with each other.

and if through sexual contact that it may be limited to a particular kind of contact:

I: I heard you speak about the infection.

Bongiwe: Of HIV?

I: Do you know how it enters the body?

Bongiwe: No I don't know, I know that it enters in these people who sell themselves, even though it does not only enter to them only.

The prevention of infections was also poorly understood. Whilst condoms were seen as possibly helpful in preventing infection none of the interviewees reported using condoms regularly if at all. Whilst Sibongile was aware of the need to use condoms for both the prevention of pregnancy and infection she was not using them herself:

Sibongile: They [educators visiting her school] used to also talk the same things, when a person has sex she must use condoms.

I: And so do you use condoms?

Sibongile: No ever since I have been having sex I have never used them.

I: Do you ever think about them?

Sibongile: Well no, truly, I have not thought of them.

I: Why?

Sibongile: I don't know really, they just never enter my mind.

I: Right now what do you think about them, not even thinking about using them, just what you think?

Sibongile: Right now I could say they are helpful because it is said that people should use them because they will not make children and all of these many diseases will not enter easily on them.

I: But?

Sibongile: I have heard that many say that they are painful.

Furthermore, in terms of prevention, Bonesoa held an alarming misconception that whilst condoms may be able to prevent the spread of STIs, these STIs could be prevented through the use of injections:

I: So what do you think is the best way to prevent AIDS and STIs?

Bonesoa: I think it is to use condoms if you feel that you are having sex or maybe come to the doctor maybe they'll give you pills or an injection to see whether they can protect you from many illnesses.

I: An injection?

Bonesoa: Yes.

I: To protect you from many illnesses?

Bonesoa: Yes.

I: Do you believe that there are injections that can protect you from STIs?

Bonesoa: Yes STIs, I am certain of it, that there is an injection that protects, say maybe inside you are already dirty [infected] it can happen that when you get injected, they can clean you, when you have sex the STI when it gets inside, it has nowhere to stay, it already comes out because the medicine is already inside.

Knowledge, or lack of knowledge, about STIs and prevention and cure amongst five of the six interviewees raises real concerns about their ability to make informed decisions which may or may not compromise their health. This, in addition to all the factors already mentioned, makes it very difficult if not impossible for young women to make informed and empowered decisions about their reproductive health and their mental and physical health in general.

4.3.3.4 Low perception of risk for sexually transmitted infections

Given the limited knowledge that the majority of the interviewees had about STIs and reproductive health it is not surprising to find that they believed themselves to be at low risk for STIs. However, even Lucy, whose knowledge of HIV/AIDS and sexually transmitted infections seemed better than the other interviewees, did not perceive herself at risk for these infections at the time of her first sexual encounter. In addition to limited knowledge there was an underlying assumption with her and Bonesoa that if one lacks sexual experience there is no vulnerability to being infected with HIV/AIDS or a sexually transmitted infection. As Bonesoa states:

Bonesoa: We did not use anything.

I: You knew about AIDS then?

Bonesoa: I knew about AIDS then, but because at the time I had not had sex, even my boyfriend I think he had not, well I don't know if he had, I just took it that we could not get AIDS or STIs, we may just get a baby only.

It is noteworthy that there is an assumption made about the boyfriend's sexual experience, and if there is doubt this cannot be asked about. Thus for Lucy, the idea that her boyfriend could have a sexually transmitted infection was not compatible with her trust in him. That he may have been sexually experienced was not something she felt was important:

Lucy: I can say I didn't know all that much so I didn't even think that it can be one of those diseases that infect me and also like he was someone that I trusted a lot you see. I wasn't sure that he could have those diseases which are like that.

I: You believed he had never had sex or he is trustworthy?

Lucy: Not that he has never done it you see, but I thought that, like I was sure that he is faithful to me because all the time, we would be together.

It seemed difficult for these young women to consider the possibility that their boyfriend's, for whom they felt some affection and attraction, might have had previous sexual contact which would now place them at risk. In addition it was assumed that as long as they were in a monogamous relationship currently the past was of no consequence.

4.3.3.5 Sources of information on reproductive health

The lack of adequate information that these young women had and have about reproductive health is worrying at this stage of the spread of the HIV/AIDS pandemic in

this region. It was clear from the interviewees that the most common source of information about HIV/AIDS was from awareness raising groups visiting their schools. This is the only time that teachers bring up sex and sexuality:

> Zanele: I used to hear them from school sometimes, we were visited by these people from [names an active HIV/AIDS awareness group] others were from, I cannot remember exactly the name of the ones who used to visit us a lot.

When mothers in these young women's lives do discuss sex, it is in a limited manner and without further discussions on sexuality and how to handle it. The experiences of these young people is that their mothers only brought up sex when their menstrual periods started and the information given was in the form of a warning that sleeping with boys would result in pregnancy. Little else if anything was discussed with the young women. Zanele recalls:

> Zanele: My mother told me that I am not supposed to sleep with boys, I will have a baby so that is what I was afraid of only, because I did not know anything at that time.

Similarly Sibongile remembers her mother warning her:

> Sibongile: She [her mother] said: "You see now that you are already menstruating don't sleep with a boy at all because you'll make a child".

The complexities of developing a sexual identity, negotiating sex as a young woman, the risks of STIs and how to prevent them is simply not addressed with these young women.

4.4 Conclusion

These young women in their first sexual encounter were to a certain extent responding to a natural curiosity about sex and searching for intimacy and identity

that is characteristic of the period of adolescence. There are various factors that these six young women had to deal with around their first sexual encounter. They had to face sex long before they had developed their own ideas and identity about sex and love. Their ideas about sex were greatly influenced by siblings and peers who were probably still searching for their own sexual identity. This has also highlighted the poor communication that these young women have with their parents about sex. These young women also had to face coercion and pressure to have sex. Two of them had been raped and all faced some coercion or pressure to have sex from their partners. They held unsafe misconceptions around the prevention of STIs and HIV along with very limited information.

CHAPTER FIVE

5. DISCUSSION

5.1 Introduction

This chapter discusses the themes that emerged out of the interviews with the six interviewees. Although each young woman interviewed described a unique experience of the first sexual contact the common themes which emerged suggest that, in many ways, they also shared similar contexts and experiences. It is clear from these themes, elucidated in the previous chapters that these young women are at very high risk for contracting Sexually Transmitted Infections including HIV/AIDS. This chapter builds on the themes and sub-themes outlined in the previous chapter and elaborates on these by reflecting on the literature discussed in Chapter Two and draws links between that and the lived experiences of the six interviewees.

5.2 What attracted the young women to the partner with whom they first had sex

Poverty has been identified as a key factor influencing sexual activity amongst young people in sub-Saharan Africa. This has been largely attributed to sex being a transaction; that is having sex in exchange for money, school books, sweets and so on. The phenomenon of 'sugar daddies,' older men who provide money or material goods to young women in return for sex is understood to be part of this transaction (Baylies, 2000). A great deal of research has been focused on the financial dependence of poor women on men leaving these women unable to negotiate issues around sex (Farmer, 1996). Harrison et al. (2001) suggests that having access to money and material goods has been one of the motivating factors in young people's sexual relationships.

However, Harrison et al. (2001) found that it is not always out of need for material goods as basic as food or shelter but it is at times out of wanting to have fashionable clothes and

to meet the expectations and demands of their peer group that young women or girls become involved in relationships or sex. However, Harrison et al. have also suggested that these findings be accepted with some caution as they may be relevant for a particular grouping of girls within a particular context.

All the young women in this study came from relatively poor backgrounds, describing periods when there is either no food or fuel, or clothes or schools fees and it would have been understandable if these young women had had sex in return for financial or material gain. However, none of the six interviewees reported these financial or material needs as a motivating factor in their first sexual relationship. In addition all of their first sexual partners were described by the interviewees as living in similar economic and social contexts to those of the young women.

The stories of these young women indicate that attraction plays an important role in the reasons they became involved in their first sexual relationships. These young women described what could be considered normal adolescent developmental needs; wanting to fall in love, a curiosity and interest in sex which is often manifested in an attraction to the opposite sex. These young women were able to describe what they found attractive. Bonesoa found that her boyfriend, who lived in the same neighbourhood as she did, had qualities she valued in her self; he was committed to school and was not "lazy to work in the garden". When examining her initial attraction to her boyfriend, she identifies qualities in him which she also had and valued at the time. In Erikson's (1968) view she was projecting her ideal self onto him so that self may become more defined for her self. Even at the age of 14, her need for intimacy is normal in adolescence and, according to Erikson (1968), is part of a key task in adolescence to move towards the establishment of a solid identity. Erickson (1968) explains the adolescent's need to fall in love as a search for identity, or a search for themselves, to find qualities in the other person of their idealized self so as to affirm themselves.

Thandi also liked the fact that her boyfriend seemed well behaved, not into sitting in a group and discussing girls. She liked that he seemed content with his own company,

perhaps a sign of maturity for her. Both Bonesoa and Sibongile expressed a physical attraction once they were in a relationship; they liked the way their boyfriends kissed them. Thandi and Sibongile expressed that they felt a certain level of physical attraction and enjoyed the physical intimacy of being touched, held and kissed. Physical attraction was as real for these young women as it is for adolescents elsewhere. They were also attracted to their boyfriends because of their physical looks. In adolescence the task to establish an identity is often fused with the process of 'falling in love' usually concomitant with an awakening of sexual feelings. This can be overwhelming for the adolescent and is likely to involve experimentation and exploration in an attempt to make sense of all these new emotions.

Nonetheless, the quest for identification is informed by and embedded within the adolescent's socioeconomic and cultural environment. It is important to bear in mind that a majority of Basotho girls grow up with major domestic responsibilities. Chores such as cooking, cleaning and taking care of younger siblings, tending vegetable gardens and if possible contributing to the family income by selling them are not unusual for young girls even from an early age. Bozalek (1997) found this to be common in African families, particularly those from poor backgrounds in South Africa. This is already a socialization of girl children into 'homemakers'. This identity is intimately linked to the role marriage plays in this culture. From early on young girls are accustomed to and prepared for their future roles of wife and mother. This is the potential and value of young girls; to be married and to bring home 'bohali' (bride wealth in cattle or money). In turn, in most rural areas, boys are seen to have the potential for generating income, often through migrant labour and to thus support the family (Murray, 1981).

This social and cultural ideal affects both boys and girls and must therefore influence early intimate relationships and sexual activity. Thus Bonesoa's attraction to her first boyfriend was not only about adolescent needs but also what she saw as their future, which is directly connected to their context and the expectations for young men and women. Culture and societal norms prepare these young women to look forward to one thing in their lives and that is to establish their own families thereby establishing their

identity. In Lesotho, the identity of a married woman is formed from her husband and his family. This does not only open up avenues for access to social to capital but also may potentially provide for financial security. The need for further education may not be seen as a primary goal, the primary goal is to form a marital alliance.

Cultural beliefs and values related to women, fertility and children may also be influencing teenage sexual activity. When a young woman gets pregnant out of wedlock in Lesotho, it is not unusual for the young man's parents to pay what is known as 'litshinyehelo' or damages. This has also been found to be common practice in Southern Africa (De La Rey and Carolissen, 1997). It is also not uncommon for the couple to be pressured into marriage by their parents. At some level, this implies that it is a common occurrence and is dealt with in a certain manner. The child also tends to be taken as a younger sibling and the care is left solely to the young woman's mother, to the extent that these children only realize late in their lives that their 'sister' is actually their mother. The care of the infant and his/her inclusion into the family has also been observed in other studies in South Africa and has been seen to be implicitly encouraging teenage pregnancy (De La Rey and Carolissen, 1997). It is noteworthy that all six interviewees in this study were pregnant or had had children by age of the 18.

The ability to bear children is seen as key to a woman's identity and is highly valued in the Basotho culture. There is a derogatory term in Sesotho which is specifically used for a woman who is infertile, 'nyopa'. A term which a young Mosotho woman does not want to be associated with at any point. Culturally there is already pressure on young women to prove their fertility, a state which is generally only the responsibility of women. This is not to suggest, however, that there are no penalties to be paid by young women for getting pregnant outside of marriage. There is always the possibility of the young man denying paternity. This is a situation which young mothers often find themselves in. In addition single young mothers are unlikely to be able to continue their education and are also now less likely to secure a husband.

The interviews suggest that these young women were not necessarily involved in their first sexual relationships for immediate financial or material support or relief. However their social, cultural and economic context clearly informs the nature of their first relationships. This is certainly true for adolescents around the world; intimacy and first sexual relationships are infused with the realities, demands and restrictions of the contexts within which they occur.

5.3 Factors which contribute towards a relationship becoming sexual

There are multiple factors that are interlinked and interdependent which are informed by social, economic and cultural context in which these young women live in. Such factors have clearly informed their decision making around their initial sexual experiences. Some of these processes were internal whereas others were outside of their control.

5.3.1 Sexual intimacy as a way of strengthening love

One of the strongest themes to emerge from the interviews with these six young women is the belief that sex strengthens or increases love. Jackson (2001) observes that love is often equated with sex amongst young women. This conflation of love and sex is promoted and encouraged by popular media. It has also been observed that young women are more likely than young men to view sex as an expression of love, intimacy and commitment (Jackson, 2001; Rosenthal and Moore, 1998). Bonesoa uses the words "we are strengthening [our love]" to explain her reason for having sex with her boyfriend. Bonesoa expressed her need for deeper intimacy by having sex, an activity which she understood to be adult and thus mature and serious. Bonesoa used the phrase 'ho tiisa' (to strengthen), a phrase that is also used to denote the process of a civil marriage in Sesotho, suggestive of sex being seen as a form of commitment. Whilst young women may equate love with sex it is often the young men who make that assertion and impose that view on their female partners (Wood et al. 1998), this will be more fully explored later in this chapter.

The idea that sex strengthens love was mentioned by all six interviewees. Yet all the young women stated that they did not enjoy their first sexual encounter. For most it was characterized by fear and pain and subsequent guilt. In 'agreeing' to have sex these young women were making a sacrifice in the name of love, thus they felt that although the experience had not been pleasurable and despite the guilt thereafter five of the young women had felt that it had nonetheless made their feelings of love stronger towards their boyfriend. There is a noticeable absence of comment on whether having sex had strengthened the boyfriend's love towards his girlfriend.

At this developmental stage, these young women are beginning to develop an understanding of what erotic love may mean for them. This is something which they must grapple with in relation to demands and expectations which often differ from their own wishes, the wishes of their families, their peers, older siblings and their boyfriend. So, for Bongiwe when her boyfriend told her that "if you don't have sex with me, you don't love me!" and then sulked and walked away it seemed clear to her what she had to do to maintain the relationship. The conflation of love and sex in relation to their first sexual encounter was evident in all the interviews and in retrospect only Lucy questioned this assumption. Lucy, was the only one who made sense of her first sexual experience as having been the result of trying to prove to her boyfriend that she loves him. Without exception all the young women stated that if they were to give advice to adolescents now they would suggest that they delay sex, but it was only Lucy who used as part of her argument that no one has to have sex to prove love to a partner and that in fact when asked to do so it is pressure, and that one need not give in to it. It may be noteworthy that Lucy was the one interviewee who delayed sex on the basis of needing to complete her schooling and who had had discussions with her mother about sex. The other interviewees all felt they had been too young; they had rushed and would have liked to start sexual activity at the age of 21, others at 25. They suggested this age because they were more likely to have finished with their education and to be a marrying age.

5.3.2 Influence from peers and older siblings

Young Basotho women gather information and develop attitudes towards sex largely through conversations with their peers and older sisters. Cultural taboos make it difficult for girls to ask questions or generally express themselves with adults, including their mothers. Such questions would be viewed as inappropriate and disrespectful. In addition whilst some information was gained from presentations at schools by local NGOs or Clinics it was clear that these presentations did not make it any easier or more acceptable for teachers to discuss issues around sex and sexuality with their learners. Thus it becomes much easier for young people to seek advice, information and discussion from their peers and /or older siblings, who appear to be far more willing to talk without shame and censure.

Thus Bonesoa had received some information from school about the dangers of sex, nevertheless, what took precedence over that was what her sister told her about her experience of sex. Her sister spoke openly about sex and suggested that it was something exciting and possible which the young Bonesoa could also experience. Consequences of sexual activity seemed to be peripheral to the excitement communicated about sex. Bonesoa reported wanting to be like her sister and consciously deciding to have sex as a result of these conversations. The influence of older siblings also comes in the form of pressure. Thandi describes that she used to hang out with older sisters a lot because they liked her. She was a quiet around them but also attentive. They would even chase other girls away but leave her to listen in on their 'adult' conversations. As adolescents these young women were already aware at that stage that they are almost as independent as adults. What separates them from being adults seems to be having sexual experience, therefore it seems natural that to prove your adulthood you must have sex. From childhood young women are prepared to be good home care givers and from a young age are competent in this role in all other ways except sex. As Bonesoa said, she wanted to be like the adults. Thandi herself makes sense of her first encounter as being largely led by

the fact that her older sisters used to encourage it. The relationship with her older cousin sister became such that she encouraged her to sleep with her boyfriend, telling her that she was still safe because she had not started her menstruation and so was not in danger of getting pregnant and that she is no longer a child.

The influence of peers in the adolescent's life is profound in this stage of development (Hook, 2002). With peers, adolescents are able to share their experiences and to talk about and ask questions about things they would otherwise not have the opportunity to find out. All the young women interviewed with the exception of Bongiwe reported that they first told their peers about their first sexual encounter. Bongiwe told her mother. Peers, unlike parents or other adults, are likely to be non-judgmental and possibly impressed by such disclosures. Thus the young women felt free enough to share their experiences with their peers and to ask them questions and advice. Zanele had only told her friend that her boyfriend had forced her to have sex, her friend had advised her to break off the relationship with him and she had done so. Peers are very powerful in the adolescent's life, a fact which is being increasingly recognised in the development of peer HIV/AIDS counseling structures. However, peers may not necessarily be supportive, but may also be the source of pressure and coercion into sexual activity as a way of staying in with the group similar to process described by Thandi in the previous paragraph.

5.3.3 Partners pleading and pressuring young women to have sex with them

It has been suggested that one of the factors that puts young women in a vulnerable position to HIV infections is the pressure to have sex which they face in their romantic relationships (Wood et al. 1998). The interviews with these six young women clearly demonstrated this. Of the six young women, Zanele was raped by her boyfriend (though she defined this as force) and five felt pressurized into having sex. Bonesoa was raped at age 13 although not by a boyfriend. The kind of pressure exerted may be seen as falling along a continuum from constant pleading and cajoling, to coercion, to violent rape.

Whilst it may be argued that pleading is hardly a form of coercion given the context within which the pleading occurs and the power imbalances between the young women and the young men in this context the concept of a continuum is useful. The pleading described by the interviewees is persistent, it often begins with a note of mature patience, suggesting that the young woman can freely exercise her choice not to have sex, however over time, the pressure increases and she is made to feel unreasonable and somewhat inadequate or childish if she refuses. Thandi's boyfriend pleaded with her in the beginning and appeared to be content with her decision not to have sex. However, as time went on the emotional pressure increased as he expressed more and more dissatisfaction about her decision. This type of 'persuasion' is likely to be keenly felt by an adolescent young woman who is trying to feel like an adult, just as the young adolescent man is trying to develop an identity of masculinity and adulthood. For both young men and women in adolescence there is an understanding that to make decisions regarding sexual activity defines them as adults in a critical way. This struggle to form an identity, knowing that one is no longer a child and realizing that one will soon be an adult is central to the developmental phase of adolescence (Graber et al. 1998).

Bongiwe describes a similar situation where she would refuse to have sex explaining that her parents had warned her against it. However, this would result in her boyfriend sulking and walking away from her. This would be followed by a familiar refrain from her boyfriend: "If you loved me you would sleep with me". Aside from the challenge to the young woman's commitment to the relationship, her maturity and status as a young adult there is another level at which this statement is likely to resonate for the young woman. As discussed earlier, culturally young Basotho women are socialized to be nurturers and are encouraged to develop skills in how to maintain a home and relationships. This requires that a woman take her cue from males. Traditionally, women are not seen as having the ability to make decisions on their own even with regard to their bodies or their children (Letuka et al. 1998; Murray, 1981). Bongiwe gave in to the pressure to have sex when she was accused of not being "good enough at giving love". Bongiwe wants to and has been taught to please men and this informs her capitulation. In the interview she clearly expressed her desire to please her boyfriend.

In conjunction with these cultural mores there is an unspoken but accepted expectation that males want sex and females delay this gratification, but must understand that ultimately if she is involved with a male sex will happen. This is quite clearly illustrated in Sibongile's account of how she came to have sex the first time. Sibongile describes how they were kissing and before she knew it things had happened. Thus although she had refused to have sex there is a point at which it is understood that refusal will be ignored. This is linked to a belief that males cannot help having sexual feelings, the gratification of these feelings must be delayed by the female but ultimately met. In her interview Sibongile stresses that whilst she acknowledges her own sexual feelings she had tried to stop her boyfriend from having full sexual intercourse with her.

Lucy was able to negotiate a time frame in which sex would happen. This time frame was dictated by educational goals. Lucy wanted to complete her grade 10 exams before having sex. Her boyfriend accepted this, but on completion of her exams was no longer interested in her protests that she did not want to have sexual intercourse. Lucy was able to delay sex by about two years but ultimately had to concede against her wishes.

Bonesoa had been raped at the age of 13 by a neighbour and family friend who is older than her. She did not share this with anyone until she was 16. She was afraid and did not want to cause trouble between the families as their mothers were friends. Her first consensual sexual experience was with her boyfriend at age 14, which she agreed to in order to strengthen their love. Zanele's experience was a painful one; she had been forced to have sex at age 14 by her boyfriend. It became clear from her description that her boyfriend at the time had raped her. She was however unable to name the experience as rape, since, "You can't say someone raped when he is your boyfriend". The powerlessness that these young women experience in relation to sex which they do not want to have is very evident in these stories and extends to the degree that they do not seek help or expect support following these events. Zanele continued to experience rape with her next boyfriend, who used force to have sex with her including twisting her arm and pushing her down.

In conclusion, perhaps what is most disturbing is that there seems to be an expectation understood to be legitimate by both parties that sex will occur. That this sex is likely to be to some degree unwanted by the female and wanted by the male is part of the inevitability of becoming sexually active. Because of this inevitably it is almost impossible for these young women to name forced sex as rape or to seek help or redress for this experience.

5.4 Risks associated with the first sexual encounter

It is clear that HIV/AIDS was not considered a primary risk for these young women, they felt other issues were more of an immediate risk and these were largely determined by the context in which they live.

5.4.1 Fear of getting 'spoilt' [pregnant]

With five of the interviewees the first concern in relation to sex which was mentioned was the possibility of falling pregnant as a result of their first sexual encounter, some were worried about this even before the encounter. This has proven to be the primary concern of the young women. Even for the girls Bonesoa and Zanele who were violently coerced into sex their primary concern remained that of falling pregnant. This is not to say that these young women were not concerned about STIs including HIV/AIDS, but given their context and in their circumstances, these concerns received little attention. In a patriarchal society such as Lesotho if a young girl falls pregnant out of wedlock she is 'spoilt' and she becomes extremely vulnerable to losing her main source of access to economic stability; marriage or education.

5.4.2 Low perception of risk for STIs

A common theme which emerged from all six interviews is that these young women did not perceive themselves to be at risk for sexually transmitted infections at the time of their first sexual encounter. This is very much in line with suggestions in current research

and literature. Whilst both Bonesoa and Lucy had some information about sexually transmitted diseases, including HIV, at the time they did not think of using condoms because they trusted their boyfriends. In addition because this was there first sexual experience they assumed that they were not at risk. Young adolescents are generally unlikely to use contraceptives of any kind, condom use is seen as signifying that one has pre-existing infections or has had or has multiple partners who have had infections (Rosenthal and Moore, 1998). For these young women to consider the possibility that their boyfriends may have an STD or HIV, or have slept with other women who have STIs would cast doubt on the kind of young man they think he is and would thus bring into question her trust of him. Sexually transmitted disease and HIV/AIDS have been seen as 'dirty' diseases carrying a lot of stigma, seen as only affecting prostitutes and promiscuous people (MacPhail and Campbell, 2001).

5.4.3 Lack of knowledge about STIs, HIV/AIDS and prevention

All of the six interviewees showed a worrying lack of basic knowledge and held some disturbing misconceptions about sexually transmitted diseases and HIV/AIDS. The misconceptions ranged from getting HIV from sharing eating utensils to the availability of an injection that can prevent sexually transmitted diseases. This lack of knowledge poses a serious threat to the reproductive and sexual health of these young women. It has been found that adequate knowledge of reproductive health has played a substantial role in delaying early sexual activity in adolescents (Rosenthal and Moore, 1998).

The main sources of information on reproductive health for these young women were schools and mothers. However the type of information they got was minimal. Most had several visits at their schools from AIDS activist groups and clinics. As a result of poverty, a majority of schools are under resourced and reproductive health education has not been part of the curriculum. Cultural norms have limited the level of communication about reproductive health, not only between parents and young people, but also between teachers and pupils. The mothers of these young women did not give them much information, they were only told when they started menstruating that they should not

sleep with boys. Mothers have great difficulty talking to their children about reproductive health, mostly because they find the subject embarrassing or they themselves do not have adequate information (Mturi and Hennink, 2002; Letuka et al. 1997; Bujra, 2000). Talking to young people about sexual matters is often left to mothers as they are seen as the ones responsible in the raising of children. Young people are also socialized to respect their elders, which means subjects like sex are taboo and if raised imply a lack of respect.

5.5 Conclusion

There are multilayered factors that impacted on these young women's decision making around their first sexual contact. Their developmental task to form an identity towards adulthood which involves sexual exploration and a search for intimacy was prominent in their involvement in a relationship. Nonetheless, the social and cultural context, where there is a clear inequality of power between men and women encouraging women to take their cues from men, has impacted on the sexual development of these young women and most probably equally so for their partners. There is little if any protection afforded these young women in the form of information on reproductive health, parental and societal guidance around issues of love and intimacy, which could instill in them a sense of being valued and thus protected within the family and society. There is nonetheless immense pressure on them to prove themselves as able to nurture and maintain families.

CHAPTER SIX

6. CONCLUSION AND RECOMMENDATIONS

This chapter draws together the key issues highlighted in the literature review with the major themes which emerged from the interviews conducted with the six young Basotho women. Limitations of this study are discussed and the chapter concludes with recommendations for intervention on the basis of the literature reviewed and interviews conducted.

6.1 Conclusion

Sub-Saharan African youth have been the most affected group in the world in terms of HIV infection, this is particularly true of young women (Giffin and Lowndes, 2002). Current research on the spread of HIV/AIDS has shown that there has been a narrow focus in knowledge which has been guiding prevention efforts against the HIV/AIDS pandemic. This approach has mainly focused on individual factors that influence sexual behaviour, such as knowledge attitudes beliefs practice. This research has adopted a largely a biomedical approach which has focused mainly on sexual behaviour, such as the number of sexual partners and the use of condoms (Wood and Foster, 1997). There are limitations to this approach as it presents an incomplete explanation and understanding of the factors which interact in determining sexual behaviour and how contextual factors render women vulnerable to HIV/AIDS in sub-Saharan Africa. Wood et al., (1998) have recognized that localized and contextualized research is essential in the understanding of the dynamics that are driving the HIV/AIDS pandemic.

Adolescence is a developmental phase which places young people in a vulnerable position in relation to the HIV/ AIDS pandemic. It is a stage which marks the transition from childhood to adulthood, which includes the sexual development of the adolescent. The individual adolescent experience is informed by the historical and political context, socioeconomic conditions and the cultural milieu. Change over time in attitudes towards sex and sexual behaviour have been evident not only in Western societies, but also in

other parts of the world including sub-Saharan Africa. (Graber et al., 1999; Kimane, 1981; Bujra, 2000). These changes are informed by broad macro issues which affect the sexual development of young people. These six young women had sex at a young age, and at a time when their knowledge of reproductive health and the nature of intimacy and relationships was extremely limited. Basotho parents have great difficulty in discussing sexuality and intimacy with their adolescent children (Mturi and Hennink, 2002). These young women were provided with very little if any guidance from the adults around them and discussion related to sex, love and intimacy were understood to be unacceptable. Whatever guidance had existed within traditional structures has been eroded and is now virtually non existent (Motlomelo and Sebatane, 1999). The information young people receive on reproductive health from their schools is limited to occasional visits from HIV/AIDS awareness groups and private clinics and is not incorporated into the daily school curriculum.

Furthermore, in Lesotho, girls are socially encouraged to become caregivers, as wives and mothers. They learn to manage households from a young age. Marriage and fertility are highly esteemed in the culture but young women are not prepared for their roles of wife or parent. They seem to have little knowledge about what these roles will entail. This is often equally true of young men. Young people are thus easily influenced and /or pressured into sexual activity for which they are not prepared. Since parents, teachers and other adults are not teaching adolescents about reproductive health and avoid talking about issues of sex and intimacy to adolescents, peers, older siblings and boyfriends appear to be the ones who have greatest influence of how young adolescent women behave sexually.

Young people in sub-Saharan Africa are also influenced by deeply entrenched cultural values. In Lesotho, unequal power relations between men and women are evident at many levels of society; in the home, schools and at the work place (Letuka et al. 1997). These values and unequal power relations inform the ways in which girls are socialized to view themselves in relation to others. They are taught to take care of the needs of others first and learn that decision making is reserved primarily for males. In addition sexual

roles are socially constructed and inform how young people behave sexually. Generally men are encouraged to be dominant and women to be submissive. Women are seen as incapable of making decisions on their own; they themselves struggle with accepting positions of authority (Letuka et al.). Women and girls are generally seen to be incapable of making decisions and this may contribute to their acceptance of their male counterparts making decisions around sex. The young women's 'decisions' to have sex was always informed by the pressure (emotional or physical) which their boyfriends put on them. This disempowerment leaves women and girls very vulnerable to being coerced into having sex and such coercion may not be defined by themselves or those around them as rape. This made it almost impossible for these six young girls to tell an adult or anyone who is in a position of authority about being coerced into sex. This leaves young women very vulnerable to HIV infection and other sexually transmitted diseases. They cannot protect themselves and are not protected by their context.

In sub-Saharan Africa women suffer the most under conditions of poverty. Poverty impacts greatly on young people, they are often unable to continue their education due to lack of financial resources, lack of money for fees, books, traveling long distances to schools as well as coping with poorly equipped schools. There is a high rate of young people dropping out of school in Lesotho (Letuka et al. 1997). Young women drop out of school because of pregnancy and being needed at home, and it is clear that within this context the prospect of becoming a wife seems a more attractive and viable option. Furthermore, unemployment and limited prospects for young women leaves them with little sense of a future in education and careers. In addition very few extra curricular activities are available to young people in Lesotho. The limited resources leave young people with time on their hands which may increase sexual activity.

In addition, in conjunction with the limited information and misconceptions that these young women had about STIs and HIV/AIDS, young people often deny being at risk for HIV infection and other sexually transmitted infections, which would encourage high risk sexual behaviour. This was evident for the six young women interviewed in this study.

The main themes summarized here suggest a number of interesting and important directions for future research and for the development of prevention strategies. Before these are considered however, the limitations of this study need to be discussed.

6.2 Limitations of the study

Given the very small sample size and the qualitative methodology employed, the results of the study cannot be generalized, either to Maseru, Lesotho or sub-Saharan Africa. The narratives which were elicited were highly individual and co-constructed between myself and the interviewees. As is the nature of qualitative research each interview is unique and does not represent the experiences of young Basotho women in general. However, the narratives do offer a glimpse into the 'private worlds' of these six young women. These 'private worlds' are informed by the 'public spheres' of socio-political and cultural contexts. They provide a way of understanding the interplay between these worlds. The current literature on HIV/AIDS also suggests that the key themes which emerged from the interviews are common to the broader research, and suggest future areas of focus for contextualised research.

Although interviews are labour intensive and time-consuming they provide a way of understanding a person's experiences in a multi-faceted way. This seems to be critical when trying to understand the spread of HIV/AIDS in Lesotho. Interviews with larger representative samples should be conducted. This includes interviews with adolescent boys and interviews with partners of a couple. In addition to the main areas covered in the semi-structured interviews conducted in this research the following areas should be considered: how adolescent boys make sense of or explain their sexual behaviour, how they understand coercion and more detailed accounts of sources of information and misinformation about STIs and HIV/AIDS, details about ongoing sexual activity (as opposed to a focus on first sexual encounter).

Furthermore a systemic understanding of young people's sexual experiences would be useful in informing intervention strategies. Research should be localised and interviews

with school teachers, parents, clinic staff and church leadership who constitute a particular community and /or neighbourhood would be instructive.

6.3 Recommendations

It is clear from this summary of key themes that the spread of HIV/AIDS amongst young women in Lesotho is influenced by a number of complex and interwoven facts. For prevention efforts in Lesotho to have an impact it would seem that a number of levels would have to be targeted simultaneously.

* One of the most important levels for intervention is the need for the improvement of legal protection of women in terms of their access to and retainment of economic resources such as property, land, finance and access to education. All children and adolescents should have their right to education protected, but this needs to be enforced. The law should also have stringent penalties for crimes of violence against women and children. Advocacy work to educate adults and children about legal help as well as help in the community when such crimes occur is important to undertake. In addition teaching young people how to recognize crimes such as rape and sexual abuse is also important.

* Another important level of intervention is education. Reproductive health should be taught in schools (Mturi and Hennink, 2002). The programmes should encourage participatory methods of learning about sexual issues such as sexual pressure and coercion and it needs to be integrated into the school curriculum. Where abstinence and the delay of sexual activity is encouraged the positive and beneficial aspects of this choice should be highlighted and discussed. Furthermore, the option of condom use should be explained and issues such as the negotiation common to condom use, as well as the advantages and problems that come with condom use need to also be discussed in schools.

* Young people need guidance from parents and other social institutions such as churches to guide and inform them about becoming young adults. Parents need to be

encouraged to speak openly about reproductive health with their young ones even before reaching adolescence. Parents need to encourage their teenagers to talk to them about physiological changes, love and sex and to feel free to ask questions. Both mothers and fathers need to be involved in shaping their children's ideas about sex. It is clear that where there are existing taboos on talking about sex, it may be easier to talk about reproductive health when it is the parents who broach the subject with confidence and openness. Communication on such issues from both parents could be of tremendous help in young women's sexual behaviour as research as also suggested that fathers play an important role in the development and sexual behaviour of girls (Ngom et al. 2003). Young men need to be included in this dialogue and need to be educated about respecting young women. Both girls and boys need to be taught to recognize when pressure and coercion to have sex is being used and that it is a form of violence .

* Health clinics and media campaigns should also promote abstinence as an option for young adolescents. Campaigns and clinics promoting condom use need to consider the complexities of using condoms , taking into account the negotiation required between men and women and the negative attitudes held by many towards condoms. In addition issues related to proper condom use needs to be clearly communicated and the fact that condoms prevent pregnancy needs to be highlighted (all six women were most concerned about pregnancy rather than STIs and HIV as result of sex). Substance abuse presents further difficulties for the practice of safe sex and is a serious problem contributing to the spread of STIs and HIV/AIDS (Motlomelo and Sebatane, 1999).

Alternative safe sex practices need to be made available to those who wish to have children. Condom use information for people already living with HIV also needs to be available, information that takes into consideration their need to have children. Discouraging people from having children is unrealistic; more information on how they can have children with a minimum risk to themselves and the unborn baby should be made accessible.

* The role of the media in the lives of young people and its part in glamorizing sex needs to be recognized by parents, teachers, clinics and churches; this should be addressed in reproductive health talks. Peers and older siblings need to be addressed about the role they can play in protecting and teaching young adolescents,.

* Religiosity needs to be encouraged as it has been proved to be a protective factor for young people and high risk sexual behaviour (McCree et al. 2003). Churches need to be involved in the prevention of HIV/AIDS addressing sexual behaviour within the church and working in co-operation with Government and non-governmental organizations in introducing their sexual behaviour programmes.

Current research in HIV/AIDS is highly informative in the issues that make young people in sub-Sahara Africa vulnerable to infection. As has been suggested contextualized research is useful in presenting a more complete picture of the complex factors driving the HIV/AIDS pandemic in sub-Saharan Africa. What is clearly emerging from that picture is that without co-operation at all levels of society millions of young people will continue to die.

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No:…….

Demographic data

1) Lemo tsa hao likae? (How old are you?)

……

2) O kena sekolo kapa oa sebetsa? (Do you work or attend school?)

……

3) O sebetsa mosebetsi o feng? (What is your work?)

……..

4) O kene sekolo ho fihlela ho kae? (What is your level of education?)

……

5) O nyetsoe? Le arohane kapa le hlalane? (Are you married/single/separated or divorced?)

……..

6) O lula toropong kapa hara motse? (Do you live in a town or in the village?)

……..

7) Ke mang eo o leng tlhokomelong ea hae? (Who is responsible for you?)

……

8) Le lula le le bakae lapeng? (How many people do you live with at home?)

……..

9) Chelete e le phelisang e tsao kae? (Who supports the family financially?)

……

10) O ka re lea sokola lapeng tabeng tsa chelete kapa le iphelela ha ntle? (would you say you struggle for money at home or you are fine?

……

Semi-structured Questions for the interview:

Ke lakatsa hore re ke re bue ka tse etsahetseng bophelong ba hao litabeng tsa thobalano, mme ke utloe le maikutlo a hoa hona litabeng tsena tsa thobalano.
I would like to hear about your experiences and opinions about sex. I would like us to talk about what has happened in your life, how you feel about it and what you think now about sex. Whatever you tell me will be fine but I will be asking you some questions

Section 1: The first sexual encounter

Ke kopa o ke o nqoqele ka khetlo lapele ha o ne o etsa thobalano.
I would like you to tell me about the first time that you had sex.

Le ne le le lemo likae? (How old were you both at the time?)

Ke ntho li feng tseo o neng o li rata ka eena? (What did you like about you him?)

Le ne le tsebane nako e kae? (How long had you known each)

Ho ne ho etsahale joang? (How did it happen?)

O ka re keng kapa ke mabaka a feng a neng ao susumetse ho ea likobong le eena? (What would you say made you decide to have sex?)

O ne o lebelletse hore ho ka etsahale ka nako eo? (Was it something that you expected to happen then?)

Le ne le le hokae? (Where did it happen?

Section2 : Emotional response

Ke kopa ho utloa ho re na o ile oa ameha joang ka mora moo? (how did you feel afterwards?)

O ile oa ikutloa ho na le phethoho ho oena ka mora hore le etse thobalano? (did you feel different after having sex)

O ne o ikutloa joang ka eena ka mora moo? (How did you feel about him then?)

Le ile la buisana ka se etsahetseng? (did you talk to him afterwards? About what?

Ho na le motho eo o ileng oa qoqa le eena ka taba tseo? (Was there someone you spoke to about it?)

Ho na le seo o neng o se touta ka mora moo (Was there something you were worried about then?)

O kile oa fumana bothata ba ho qobelloa ho etsa thobaloano? (Have you ever been forced to have sex?)

Ho ne ho etsahaleng? (What happened?)

Section3: knowledge about sex

O ne o tseba eng ka thobalano ka khetlo leo la pele? (what did you know about sex at the time of first encounter?)

Ke mang ea neng a o joetse ka thobalano? (who told you about sex?)

Ha o bona ho ne ho etsahale ka nako e neng eo loketse? (Do you think it happened at the right time for you?)

O ka fetola eng ha o se o ka khutlela morao nakong eo? (what would you change about that time?)

O ka joetsa mocha oa ngoanana ea lilemong tseo eng ka thobalano? What would you tell a young girl that age about sex?

O ithutile eng ka thobalano hae sale ele hoo? (what have you learned about sex since then?

Section4: Attraction

Ke lintho li feng tseo khahlang ho motho oa abuti? (What are the things that attract you to a guy?)

O na le mohlankana/molekane? (do you have a boyfriend?)

Section5: Knowledge about STIs and HIV/AIDS

O ka ntjoetsa eng ka mafu a likobo (What can you tell me about STIs?)

O ka ntjoetsa eng ka HIV/AIDS? (What can you tell me about HIV/AIDS?)

Ha o bona mokhoa oa bohlokoa ka ho fetisisa oa ho thibela mafu a likobo le HIV/AIDS ke o fe? (What is the best way to prevent STIs and HIV/AIDS?)

Litaba tse o ne o li utloe ho kae? (where did you get the information?)

O tsamaea litleniking tsa thero ea malapa? O ela litsebeletso li feng moo? (Do you go to family planning clinics, for what services?)

MINISTRY OF HEALTH AND
SOCIAL WELFARE
P.O. BOX 514
MASERU

LESOTHO

September 12, 2003

H\ORG\37

MS SERIALONG MOKITIMI
INTERN CLINICAL PSYCHOLOGIST
P.O. BOX 10411
MASERU 100

Dear Ms. Mokitimi,

RE: REQUEST FOR PERMISSION AND TO CARRY OUT INTERVIEWS FOR RESEARCH PURPOSES

Thank you for your request dated 13 August, 2003 on the above subject.

I am happy to inform you that the Ministry of Health and Social Welfare gives you permission to conduct your research project however you are advised that the raw data is the property of Ministry of Health & Social Welfare.

Please provide an update regularly to Head Disease Control and a final report of findings to the Ministry.

Your assistance would be highly appreciated. Good Luck

Sincerely,

Signed by candidate

DR. T. RAMATLAPENG
DIRECTOR GENERAL OF HEALTH SERVICES

DIRECTOR GENERAL
12 SEP 2003
OF HEALTH SERVICES